FY14 / FY15

Title V Block Grant

Funding Opportunity Announcement

INDIANA STATE DEPARTMENT OF HEALTH

Maternal and Child Special Health Care Services
(MCSHCS)

APPLICATION DUE DATE

Friday, May 03, 2013
5:00 PM EST

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FUNDING OPPORTUNITY DESCRIPTION

PURPOSE

The purpose of this Funding Opportunity Announcement (FOA) is to fund competitive grants for nonprofit organizations, local health departments, and health care entities within the State of Indiana for programs and services available to:

Pregnant women and infants up to age 1
Prenatal Care Coordination
Children ages 1 to 9
Adolescents ages 10 to 24
Women of childbearing ages 14 to 44
Families for family planning
Children & Youth with Special Health Care Needs age 0-21

SUBMISSION INFORMATION

To be considered for funding, applications must be received by the ISDH no later than **Friday, May 03, 2013 at 5:00 PM EST.**

MAIL ALL APPLICATIONS & ALL SUPPLEMENTAL MATERIALS TO THERESA HUNTER, TITLE V PROGRAM LIAISON:

Indiana State Department of Health
Division of Maternal and Child Health
c/o Theresa Hunter, Title V Program Liaison
2 N. Meridian St.
Indianapolis, IN 46204

*Please write on the outside of the envelope your organization name, program name, and contact information.

Applicants must use the **TITLE V APPLICATION** document (please do not alter the format). Application must include all required information in the checklist found in the **TITLE V APPLICATION**.

*Applicants must submit all documents, including the **TITLE V APPLICATION** and Supplemental Materials by mail; the following additional guidelines must be followed: Submit the original packet in its entirety PLUS three complete copies (4 total packets)

Single-sided printing

Ensure the documents are received by ISDH by **Friday, May 03, 2013 at 5:00 PM EST.**

GRANTEE MEETING

ISDH will conduct a **grant application workshop** to provide technical assistance with the grant application procedure on Friday, April 19th, 2013 from 12:00pm to 3:00pm in Rice Auditorium located in the lower level of the ISDH offices at 2 North Meridian, Indianapolis, IN 46204. Attendance at this workshop is strongly recommended for all prospective applicants.

INFORMING LOCAL HEALTH OFFICERS

Funded projects are expected to collaborate and/or consult with local health departments. If you are unable to submit a letter of support from the local health officer, you must at least submit, when requested by ISDH, copies of letters sent to the local health officer(s) in the proposed service area. These letters are for the purpose of informing the local health officer(s) of your application and requesting support, agreement, and/or collaboration.

DESCRIPTION OF FUNDING OPPORTUNITY

The ISDH Maternal and Child Health (MCH) Division and Children with Special Health Care Needs (CSHCN) Division are requesting applications from local and statewide service providers and planning organizations for competitive grant funding.

Funding will be used to develop and implement programs focused on MCSHCS's "Service Categories" (pregnant women and infants up to age 1; children ages 1 to 9; adolescents ages 10 to 24; women of childbearing ages 14 to 44; family planning; and children & youth with special health care needs age 0-21).

This is a new grant application and will be open to all projects proposing to address one or more of the Service Categories and their associated priority areas. Funding will not exceed two years (24 months).

BACKGROUND OF TITLE V FUNDS

As one of the largest Federal block grant programs, Title V is the key source of support for promoting and improving the health of the nation's mothers and children. When Congress passed the Social Security Act in 1935, it contained the initial key landmark legislation which established Title V. The Federal Health Resource and Services Administration (HRSA) through the Maternal and Child Health Bureau (MCHB) is responsible for awarding block grants to each state.

The MCSHCS Division in the State Health and Human Services Commission of ISDH is the entity to which federal funds are awarded. In turn, ISDH makes a portion of these funds available to service providers and planning organizations throughout the state to improve the health and wellbeing of all mothers and children in the State of Indiana.

LIFE-COURSE HEALTH PERSPECTIVE

ISDH's Divisions of MCSHCS are following new federal recommendations from the MCHB in applying the life-course perspective to health care needs and services. This new perspective addresses determinants of health by recognizing that each person's health and wellbeing reflects a culmination of their own unique history and is determined by social, economic, environmental and health factors.

Therefore, birth outcomes and the health and wellbeing of women and children are not only predicted by a mother's experiences during pregnancy, but also by her experiences and exposures throughout her life as well as the experiences and exposures of the lives of her ancestors. This perspective focuses on optimizing health at every stage of one's life recognizing that who we are today impacts our future mothers and children.

In implementing the life-course perspective, the MCSHCS Division of ISDH identified five service categories:

Pregnant Women / Infants 0-1
Children (ages 1-9)
Adolescents (ages 10-24)
Women of Childbearing Ages (ages 14-44)
Family Planning

These Service Categories enable MCSHCS to better understand the needs of each age- specific group. It also allows MCSHCS to provide services through the life-course perspective and understand how services can impact each population.

In addition to these age-specific categories, the Division of Children with Special Health Care Needs (CSHCN) collaborates with the MCH Life-course Health Systems team to include the perspective of children and youth with special health care needs and their families. The CSHCN Division focuses on system improvement efforts that promote family-centered, accessible, comprehensive, coordinated, continuous, compassionate and culturally effective care to CYSHCN and their families through statewide partnerships with family support organizations, Medicaid, hospitals and

providers of medical services. The Division also assists families of children who have serious, chronic medical conditions from birth to 21 years of age pay for medical care.

IDENTIFIED PRIORITY AREAS WITHIN SERVICE CATEGORIES

In July 2010, ISDH submitted Indiana's Five Year Needs Assessment for FY 2011 to FY2015 to the Federal Department of Health and Human Services' Maternal and Child Health Bureau. The needs assessment was the result of a collaborative effort that included staff from the MCH and CSHCN Divisions; professionals, parents, and community partners; and other ISDH divisions and state governmental agencies.

The Needs Assessment identifies **State Priority Areas (SPA)** that were selected through a data-driven needs assessment process with statewide citizen input. The health priorities include improving health outcomes for pregnant women, infants, children, adolescents, women of childbearing age, and children with special health care needs.

In addition to the SPAs, MCHB requires that all states address **National Priority Areas (NPA)** that describe specific MCSHCS needs. When successfully addressed, NPAs can lead to a better health outcome within a specific timeframe.

Finally, ISDH's MCH Division has identified **Family Planning Priority Areas (FPA)** that describe specific needs pertaining to women of childbearing ages and family planning. Also listed are **Family Planning Administrator (FPAP)** Priority Areas required for any entity requesting for funds to act as the Family Planning Administrator.

The following table, Identified Priority Areas by Service Category, contains a listing of both SPAs and NPAs under the appropriate Service Category.

These tables are important to your application! MCSHCS *will only consider applications that address one or more of the Service Categories and associated SPAs/NPAs.*

Identified Priority Areas by Services Category

Pregnant Women/Perinatal

SPA#2 (breastfeeding): Increase the percentage of women who initiate exclusive breastfeeding for three months and continue to breastfeed for six months

SPA#4 (perinatal care): Increase the percent of women (especially black women) with a live birth whose prenatal visits were adequate

SPA#3 (smoking): Reduce smoking among all women of childbearing age / Decrease the percent of women who are pregnant who smoke (especially on Medicaid)

SPA#8 (obesity): Decrease the percent of those who are obese

SPA# 1 (SIDS / SUIDS): Decrease rate of suffocation deaths in infants

SPA#7 (prematurity): Decrease the percent of preterm births

NPA#17 (low birth weight): Increase the percent of very low birth weight infants delivered at facilities for high risk deliveries and neonates

Children 1-9

SPA#5 (lead poisoning): Decrease the percent of children less than 72 months of age with blood lead levels equal to or greater than 10 micrograms per deciliter

SPA#10 (social/emotional health): Build capacity for promoting social and emotional health in children birth to age 5

NPA#14 (obesity): Decrease the percent of children, ages 2-5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile

NPA#9 (sealants): Increase the percent of third grade children who received protective sealants on at least one permanent molar tooth

NPA#7 (immunizations): Increase the percent of 19-35 months old who have received a full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilis Influenza, Hepatitis B

NPA#13 (insurance): Decrease the percent of children without health insurance

Adolescents 10-24

NPA #16 (suicide): Decrease the rate (per 100,000) of suicide deaths among youths aged 15-19

NPA#8 (births to teens): Decrease the rate of births (per 100,000) for teenagers ages 15-17

SPA#8 (obesity): Decrease the percent of those who are obese

SPA#9 (STIs): Decrease percent of high school students who become infected with STIs

Women of Child-bearing Age

SPA#6 (birth spacing): Decrease the percent of births that occur within 18 months of previous birth to the same birth mother

FPA #2 (preconception /inter-conception health): Increase number of women receiving preconception counseling prior to pregnancy

FPA #1 (unintended pregnancies): Reduce unintended pregnancy among women of childbearing age

SPA#3 (smoking): Reduce smoking among all women of childbearing age / Decrease the percent of women on

who smoke (especially on Medicaid)

SPA#8 (obesity): Decrease the percent of those who are obese

Family Planning

Family Planning Administrator Priority

Areas: FPAP#1: Award Sub-Grants

FPAP#2: Serve as liaison between ISDH and Sub-Grantees for Family Planning activities

FPAP#3: Provide technical assistance to Sub

Grantees FPAP#4: Monitor and Report on status of

Sub-Grantees FPAP#5: Fiscal oversight

Sub-Grantees Funded by FPAP Priority Areas:

FPA #1 (unintended pregnancies): Reduce unintended pregnancy among women of childbearing age

FPA #2 (preconception): Increase women with preconception counseling prior to pregnancy/ SPA #6 Decrease the percent of births occurring within 18 months of previous birth

FPA# 3 (exams): Increase the percent of clients who receive a pelvic examination within the past 12 months

SPA#8: (obesity): Reduce overweight and obesity

SPA#3 (smoking): Decrease the percent of women who smoke (especially on Medicaid)

NPA#8 (births to teens): Decrease rate of births (per 100,000) for teenagers ages 15-17

SPA#9 (STIs): Decrease percent of STIs (specifically gonorrhea and Chlamydia) among women of childbearing ages & high school students

SPA #6 (birth spacing): Decrease the percent of births occurring within 18 months of previous birth

Children with Special Health Care Needs

NPA#1 (family involvement): Increase percent of children with special health care needs age 0-18 years whose family's partner in decision making at all levels and are satisfied with the services they receive

NPA#2 (medical home): Increase percent of children with special health care needs age 0-18 who receive coordinated, ongoing, comprehensive care within a medical home

NPA#3 (insurance): Increase percent of children with special health care needs age 0-18 whose families have adequate private and/or public insurance to pay for the services they need

NPA#4 (early screening): Increase percent of children age 0-21 who are screened early and continuously for special health care needs

NPA#5 (services): Increase percent of children with special health care needs age 0-21 whose families report the community-based service system are organized so they can use them easily

NPA#6 (transition services): Increase percent of youth with special health care needs who received the services necessary to make transition to all aspects of adult life, including adult health care, work, and independence

AWARD INFORMATION

SUMMARY OF FUNDING

Applicants should thoroughly describe the scope of the proposed project and justify their budget request for each category of allowable services for which they are applying. Applicants should clearly request funding for two (2) fiscal years in their grant application submissions. Funding for all approved budget periods beyond the first year of the grant is contingent upon the availability of funds, satisfactory progress of the project, and adequate stewardship of grant funds. The anticipated start date for grants awarded under this announcement is **October 1, 2013**. MCH and CSHCN are focused on building systems of care. Instead of funding isolated programs and services, MCH and CSHCN will provide funds for those who can collaborate and build integrated systems, especially those that enhance service capacity.

ELIGIBILITY & REQUIREMENTS

Applicant organization:

- Must be a non-profit organization, health department, hospital, or other health care related entity
- Must collaborate with traditional and nontraditional agencies or organizations
- Must address one or more Service Categories as identified in the previous section
- Must serve populations within Indiana
- Must comply with contractual & financial requirements as listed in the Budget Section.

APPLICATION REVIEW INFORMATION

Additional evaluation weight will be assigned to projects that:

- Provide services in high risk counties as identified in the attached Maps Section.
- Incorporate the life-course perspective into planning
- Address multiple SPAs and NPAs within a Service Category
- Include models with evidence of effectiveness based on evaluation research
- Promote collaboration and building comprehensive systems of care
- Incorporate cultural competency
- Involve community members and organizations for input on services

APPLICATION INSTRUCTIONS

Please use the **TITLE V APPLICATION** document for all required Application Information. The following outlines each Section to be completed in the **TITLE V APPLICATION** document:

Section	Section Heading
Section 1	Instructions
Section 2	Completion Checklist
Section 3	Application Cover Page
Section 4	Abstract
Section 5	Application Narrative 5-A: Org Capacity / Background 5-B: Needs Assessment 5-C: Goals/Objectives 5-D: Activities 5-E: Staffing Plan 5-F: Resource Plan 5-G: Evidence-Based Programming 5-H: Evaluation Plan 5-I: Literature Citations
Section 6	Budget Information 6-A: Budget Revenue FY2014 6-B: Budget Revenue FY2015 6-C: Budget Match FY2014 6-D: Budget Match FY2015 6-E: Budget Expenses FY 2014 6-F: Budget Expenses FY 2015 6-G: Budget Narrative FY 2014 6-H: Budget Narrative FY 2015
Section 7	Required Attachments 7-A: Bio Sketches 7-B: Job Descriptions 7-C: Timeline 7-D: Action Plan Tables 7-E: Outcome Forms
Section 8	Additional Required Documents 8-A: IRS Tax Determination Letter 8-B: Org Chart & Program Specific Org Chart 8-C: Letters of Support / Agreement / MOUs

COMPLETION CHECKLIST

Please use the **TITLE V APPLICATION** document, which includes the Completion Checklist in Section 2.

This serves as a guide to ensure that all appropriate and required materials are submitted with the **TITLE V APPLICATION** document. Double click on each check box to indicate a "check mark" for completion.

Please note that the checklist includes a checkbox indicating that the applicant agency has notified its Local Health Officer about its intent to apply for MCSHCS funding. For recordkeeping and audit purposes, please retain a copy of the letter sent to Local Health Officer. This document does not need to be submitted, but may be requested upon funding approval.

APPLICATION COVER PAGE (2 PAGES MAX)

Please use the **TITLE V APPLICATION** document, which includes the Cover Page in Section 3. Please list Name, Title, and signature of the following individuals within the applicant agency:

Authorized Executive Official
Project Director
Person of Contact
Person Authorized to make legal and contractual agreements

ABSTRACT (1 PAGE MAX)

Please use the **TITLE V APPLICATION** document, which includes the Abstract in Section 4. This summary will provide the reviewer a succinct and clear overview of the proposed project. The summary should be the last section written and reflect the narrative. Please include a brief description of the project with the following:

Briefly describe the purpose of the proposed project and the anticipated accomplishments (goals), including knowledge gained, and describe the measurable objectives to achieve the accomplishments.
Briefly describe the target population and its needs and discuss why the specific interventions proposed are expected to have a substantial positive impact on the appropriate performance measure(s).

APPLICATION NARRATIVE

Please use the **TITLE V APPLICATION** document, which includes the Narrative in Section 3. All required headings are listed with respective character limitations. Character limits include spaces. Please do not alter the format of the document.

Applicants are strongly encouraged to discuss development of project specific outcomes and performance measures with MCH Consultants before submitting application. Please see list of MCH contacts.

SECTION 5-A: ORG BACKGROUND / CAPACITY (4,000 CHARACTER LIMIT)

Please use the **TITLE V APPLICATION** document. This section will enable the reviewers to gain a clear understanding of your organization and its ability to carry out the proposed project—in collaboration with local partners.

Discuss the history, capability, experiences, and major accomplishments of the applicant organizations

Discuss the history, capability, experiences, and major accomplishments of the partnering organizations

SECTION 5-B: NEEDS STATEMENT (8,000 CHARACTER LIMIT)

Please use the **TITLE V APPLICATION** document. This section must describe the nature of the problem(s) and the need for and significance of the project in the specific community or population, as it relates to your selected Service Categories. It is intended to help reviewers understand the need for the specific proposed strategies within the context of the community in which the strategies will be implemented. With respect to the primary purpose and goals of the grant program, please:

Describe and justify your *population(s)* of focus (demographic information on the population of focus, such as race, ethnicity, age, socioeconomic status, geography must be provided).

Describe and justify the *geographic area* to be served.

Describe the needs and extent of the need (e.g. current prevalence rates or incidence data) for the population(s) of focus based on data.

Provide sufficient information on how the data were collected so reviewers can assess the reliability and validity of the data.

Documentation of need may come from a variety of qualitative and quantitative sources.

The quantitative data can come from local epidemiologic data, State data (e.g. from state needs assessment or state vital statistics data), and/or national data.

Please site all references (do not include copies of sources).

Describe how the needs were identified.

Describe existing service gaps.

SECTION 5-C: GOALS/OBJECTIVES (6,000 CHARACTER LIMIT)

Please use the **TITLE V APPLICATION** document. This section must describe the *goals and objectives* of the project. These must relate to the Service Category area(s) you intend to address.

Provide the overall project goal and each objective. Ensure the objectives are *S*pecific, *M*easurable, *A*chievable, *R*ealistic, and *T*ime-bound (SMART Objectives)

Clearly state the unduplicated number of individuals you propose to serve (annually and over the entire project period) with grant funds, including the types and numbers of services to be provided and the anticipated outcomes.

Describe how achievement of the goals will produce meaningful and relevant results (e.g. increase access, availability, prevention, outreach, treatment and/or intervention).

Describe and provide a rationale for the anticipated impact the proposed project will have on your community (e.g., improve birth outcomes, decrease E.R. visits for CSHCN, decrease adolescent suicides). Impact is more goal-oriented, while results are more process oriented.

SECTION 5-D: ACTIVITIES (10,000 CHARACTER LIMIT)

Please use the **TITLE V APPLICATION** document. This section must describe the *activities* of the project. These must relate to the proposed objectives.

Describe how the proposed service(s) or practice(s) will be implemented.

Describe how you will identify, recruit and retain the population(s) of focus. Using your knowledge of the language, beliefs, norms and values, and socioeconomic factors of the population(s) of focus, discuss how the proposed approach addresses these issues in outreaching, engaging, and delivering programs to this population e.g. collaborating with community gatekeepers.

Describe how you will ensure the input of youth and families in assessing, planning and implementing your project.

Identify any other organizations that will participate in the proposed project. Describe their roles and responsibilities and demonstrate their commitment to the project.

Show that the necessary groundwork (e.g. planning, consensus development, development of memoranda of agreement, identification of potential facilities) has been completed or is near completion so that the project can be implemented and service delivery begin as soon as possible and no later than 4 months after the grant award.

Describe the potential barriers to successful conduct of the proposed project and how you will overcome them.

Describe your plan to continue the project after the funding period ends (sustainability). Also, describe how program continuity will be maintained when there is a change in the operational environment (e.g. staff turnover, change in project leadership) to ensure stability over time.

SECTION 5-E: STAFFING PLAN (6,000 CHARACTER LIMIT)

Please use the **TITLE V APPLICATION** document. This section must describe the *staff currently available* and *staff to be hired* to conduct the project activities.

List and describe the staff positions for the project (within the applicant agency and its partner organizations), including the Project Director and other key personnel, showing the role of each and their level of effort or full-time equivalency (FTE) and qualifications.).

Regardless of whether a position is filled or to be announced, please discuss how key staff have / will have: experience working with the proposed population; appropriate qualifications to serve the population(s) of focus; familiarity with cultures and languages or the proposed populations.

For positions already filled, provide a brief Biosketch, found in the **TITLE V APPLICATION** document Section 7-A for five key personnel (note: more than five may be listed, but please include only five BioSketches.

For position to be announced and positions currently filled, please provide a brief Job Description, found in the **TITLE V APPLICATION** document Section 7- B for up to five key personnel to be hired (note: more than five may be hired, but please include only five Job Descriptions).

For positions already filled, please provide the license number for all RNs and physicians.

Demonstrate how the applicant agency and its partner organizations have linkages to the population(s) of focus and ties to grassroots/community-based organizations that are rooted in the culture(s) and language(s) of the population(s) of focus.

SECTION 5-F: RESOURCE PLAN / FACILITIES (4,000 CHARACTER LIMIT)

Please use the **TITLE V APPLICATION** document. This section must describe the *facilities* that will house the proposed services.

Describe resources available (within the applicant agency and its partner organizations) for the proposed project (e.g., facilities, equipment)

Provide evidence that services will be provided in a location that is adequate and accessible.

Assure that project facilities will be smoke-free at all times

Assure that hours of operation are posted and visible from outside the facilities.

Explain how the facilities/equipment are compliant with the Americans with Disabilities Act (ADA) and amenable to the population(s) of focus. If the ADA does not apply to your organization, explain why.

SECTION 5-G: EVIDENCE -BASED PROGRAMMING (5,000 CHARACTER LIMIT)

Please use the **TITLE V APPLICATION** document. Identify the *evidence based service(s) or promising practice(s)* that you propose to implement and discuss how it addresses the purpose, goals and objectives of your proposed project. Please cite the sources of your information.

Discuss the evidence that shows that this practice is effective with your population(s) of focus.

If the evidence is limited or non-existent for your population(s) of focus, provide other information to support your selection of the intervention(s) for the population(s).

Identify and justify any modifications or adaptations you will need to make (or have already made) to the proposed practice(s) to meet the goals of your project and why you believe the changes will improve the outcomes.

SECTION 5-H: EVALUATION PLAN (8,000 CHARACTER LIMIT)

Please use the **TITLE V APPLICATION** document. All applicants are required to collect *data for monitoring purposes*. This information must be reported in the F2014 Annual Performance Report. In this section, applicant organization must document its ability to collect and report on the required performance measures as specified in the Outcome Forms of Section 7-E of the **TITLE V APPLICATION** document.

Process Outcomes Evaluation (for each of the bullets below, please list responsible staff and frequency)

- Describe plan for data *collection*. Specify and justify all measures or instruments you plan to use.
- Describe plan for data *management*. List responsible staff.
- Describe plan for data *analysis.* List responsible staff.
- Describe plan for data *reporting*.
- Describe methods to ensure continuous quality improvement, including consideration of disparate outcomes for different racial/ethnic groups (activities can include: chart audits, client surveys, presentation evaluations, observations).
- Describe how information of process outcomes will be routinely communicated to program staff.
- Describe plan for protection of client privacy, following HIPAA requirements.

Objective Outcome Evaluation

- List specific measurable outcomes for each *objective* and its corresponding *activities* listed in Sections 7-D (Action Plan Tables) and 7-E (Outcome Forms).

Overall Outcome Evaluation

- Describe plan of action if process outcomes or objective outcomes are not on target during a quarterly or year-end evaluation
- Describe who is responsible for revisiting activities to make changes for improved outcomes.

- Describe how new data as a result of the program will be used to guide the project in the future.
- Describe how process outcomes and objective outcomes will be disseminated to stakeholders within the applicant agency, its partnering agencies, and throughout local and statewide communities.

SECTION 5-I: LITERATURE CITATIONS (4,000 CHARACTER LIMIT)

Please use the **TITLE V APPLICATION** document. In this section, please list complete citations for all references cited, including (American Psychological Association [APA] style is recommended):

Document title

Author

Agency

Year

Website (if applicable)

BUDGET INFORMATION

Please use the **TITLE V APPLICATION** document, which includes formats for each of the required attachments listed below. For Budget-related questions, please contact ALISHA BORCHERDING, MCH Business Manager at Aborcherding@isdh.in.gov or (317) 233-7129.

SECTION 6-A: BUDGET REVENUE FY 2014

SECTION 6-B: BUDGET REVENUE FY2015

Please use the **TITLE V APPLICATION** document, Sections 6-A and 6-B to fill out the required Budget Narrative information.

Sources of Anticipated Revenue

List all anticipated revenue according to source. If the project was funded in previous years with TITLE V funds, estimate the cash you expect to have available from the previous year. This estimated cash-on-hand should be indicated by 400.1 and/or 400.2, respectively. If the estimated cash balance is negative, please list the estimate as $0. All revenue used to support the project operations must be budgeted.

Projects must include matching funds equaling a minimum of 30% of the TITLE V budget. **"In-kind" contributions are not to be included in the budget. Projects that cannot meet these requirements must provide written justification in the budget narrative.** Matching funds are subject to the same guidelines as TITLE V funds (i.e., no equipment, food, entertainment or legislative lobbying). Costs of a modem line for each of your TITLE V computers and costs of Internet access are allowable.

Non-matching funds are additional sources of support that are not included in the match. These funds are not subject to MCH guidelines. ***Hint: Do not overmatch. Funds supporting the program that are above the minimum 30% match requirement may be listed as "Other Nonmatching"***.

In the space at the bottom of Section I, please be sure to indicate how many hours are worked in a "normal" work week. This is usually determined by the applicant agency's policies.

SECTION 6-C: BUDGET MATCH FY 2014
SECTION 6-D: BUDGET MATCH FY2015

Please use the **TITLE V APPLICATION** document, Sections 6-C and 6-D to fill out the required Budget Narrative information.

Estimated Cost and Clients to be Served

It is essential that this form be completed accurately because the information will be used in your contract. Your project will be accountable for the services that are listed and the number estimated to be served.

Estimate the TITLE V Cost per Service listed e.g. how much of your TITLE V grant you propose to expend in each service. Figures for this, by service category, are listed in the column entitled **TITLE V COST PER SERVICE**. The total at the bottom of this column should equal the MCH grant award request.

Estimate the TITLE V Matching Funds allocated per service listed e.g., how much of the TITLE V match you propose to expend in each service. The total at the bottom of this column should equal the total match you are adding to the TITLE V award to fund this program.

Estimate the number of unduplicated clients by service category who will receive each service in the column titled **"TOTAL UNDUPLICATED NUMBER ESTIMATED TO BE SERVICED"** by both TITLE V and TITLE V Matching Funds.

SECTION 6-E: BUDGET EXPENSES FY 2014

SECTION 6-F: BUDGET EXPENSES FY2015

Please use the **TITLE V APPLICATION** document, Sections 6-E and 6-F to fill out the required Budget Expense information.

Enter the amount of your total project budget in the –Total Funds Column

Next in the –TITLE V Funds‖ enter the amount that you have requested from TITLE V. This also should match what you have entered in Schedule A of the Budget Narrative Form in –Total TITLE V.

Next enter the amounts you have included as match in the appropriate columns under –Matching Funds‖. These amounts should add up to what you have put on Schedule A of the Budget Narrative as matching funds.

Next please enter the total amount of funds you plan to use towards the implementation of this project that come from other sources in the –Non Matching‖ column.

In the column –Normal Work Week. Hours Budgeted Project‖ please enter the amount of hours each staff person will spend working on the MCH project only. *Cells in this column should reflect the number of hours worked in a week by all staff in each job classification, e.g., a project with two nurses working 40 hours per week and one nurse working 20 hours per week should enter 100 hours for 111.400.

Calculate the total across the form.

*These Numbers Should Represent The Same Information You Have Provided On Your Budget Narrative Forms.

SECTION 6-E: BUDGET NARRATIVE FY 2013
SECTION 6-F: BUDGET NARRATIVE FY2014

Please use the **TITLE V APPLICATION** document, Sections 6-G and 6-H to fill out the required Budget Narrative information.

The budget narrative must include a justification for every TITLE V line item. Each narrative statement should describe what the specific item is, how the specific item relates to the project, and how the amount shown in the TITLE V budget was derived. Staff information must include staff name, position, hours worked on the project, salary, and a brief description of duties. In-state travel information must

include miles, reimbursement ($.40 per mile), and reason for travel. All travel reimbursement must be within ISDH travel policy (available on request)

Round all amounts to the nearest dollar.

Create a separate budget for Fiscal Year (FY) 2014 and for FY 2015. FY 2014 runs October 1, 2013 through September 30, 2014. FY 2015 runs October 1, 2014 through September 30, 2015.

The Budget Narrative Form does not provide a column for TITLE V Matching Funds but does provide a column for Total TITLE V + TITLE V Matching.

Schedule A:

- For each individual staff, provide the name of the staff member and a brief description of their role in the project.
- If multiple staff are entered in one row (for instance, 111.400 Nurses) a single description may be provided if applicable.
- Each staff member must be listed by name. Calculations must be provided for each staff member in the Calculations column.
- This calculation should be in the form Salary = $/hr; X hours per week, X weeks per year.
- Fringe may be calculated for all staff. If different fringe rates are used for different categories of staff, Fringe may be calculated by category.

Schedule B:

- List each contract, general categories of supplies (office supplies, medical supplies, etc.), travel by staff member, and significant categories in Other Expenditures (such as Indirect) in the appropriate column. Provide calculations as appropriate.
- Calculations are optional for Contractual Services.
- Travel must be calculated for each staff member who will be reimbursed and may not exceed $0.40 per mile.

DEFINITIONS - REVENUE ACCOUNTS

Account	Account Title	Description
413	TITLE V Grant Request	Funds requested as reimbursement from the Indiana State Department of Health for project activities.
Matching Funds*		*Cash used for project activities that meet the matching requirements.**
417	Local Appropriations	Monies appropriated from the local government to support project activities, e.g., local health maintenance fund.
419	First Steps	Monies received from First Steps for developmental disabilities services.
421	Donations – Cash	Monies received from donors to support project activities.
424	United Way/March of Dimes	Monies received from a United Way/March of Dimes agency to support project activities.
432	Title XIX – Hoosier Heathwise and Title XXI, CHIP	Monies received from Hoosier Healthwise and CHIP as reimbursement provided for services to eligible clients.
434	Private Insurance	Monies received from public health insurers for covered services provided to participating clients.
436	Patient Fees	Monies collected from clients for services provided based on MCH approved sliding fee schedule, including walk-ins.
437	Other Matching	Other income directly benefiting the project and not classified above which meets matching requirements.
Nonmatching Funds		*Funds that do not meet matching requirements.*
433	Title XX	Monies received from State Title XX agency (Family and Social Services Administration) for reimbursement provided for family planning services to eligible clients.
439	Other Nonmatching	Other income directly benefiting the project and not classified above which does not meet matching requirements.
Estimated Cash on Hand as of 9/30 of last FY		*Monies received by the project during the previous fiscal years and not yet used for project expenditures.*
400.1	Matching Cash on Hand	Those monies received during previous years from sources classified as matching.
400.2	Nonmatching Cash on Hand	Those monies received during previous years from sources classified as non-matching.

**** Matching requirements include:***

1. Amounts are verifiable from grantee's records.
2. Funds are not included as a matching source for any other federally assisted programs.
3. Funds are allocated in the approved current budget.
4. Funds are spent for the TITLE V project as allocated and the expenditure of these funds is reported to ISDH.
5. Funds are subject to the same guidelines as ISDH grant funds (i.e., no food, entertainment or legislative lobbying).

SCHEDULE A - CHART OF ACCOUNT CODES

111.000 PHYSICIANS

- Clinical Geneticist
- Family Practice Physician
- General Family Physician
- Genetic Fellow
- Medical Geneticist
- Neonatologist
- OB/GYN
- Other Physician
- Pediatrician
- Resident/Intern
- Substitutes/Temporaries
- Volunteers

111.150 DENTISTS/HYGIENISTS

- Dental Assistant
- Dental Hygienist
- Dentist
- Substitutes/Temporaries
- Volunteers

111.200 OTHER SERVICE PROVIDERS

- Audiologist
- Child Development Specialist
- Community Educator
- Community Health Worker
- Family Planning Counselor
- Genetic Counselor (M.S.)
- Health Educator/Teacher
- Occupational Therapist
- Outreach Worker
- Physical Therapist
- Physician Assistant
- Psychologist
- Psychometrist
- Speech Pathologist
- Substitutes/Temporaries
- Volunteers

111.350 CARE COORDINATION

- Licensed Clinical Social Worker (L.C.S.W.)
- Licensed Social Worker (L.S.W.)
- Physician
- Registered Dietitian
- Registered Nurse
- Social Worker (B.S.W.)
- Social Worker (M.S.W.)
- Substitutes/Temporaries
- Volunteers

111.400 NURSES

- Clinic Coordinator
- Community Health Nurse
- Family Planning Nurse Practitioner
- Family Practice Nurse Practitioner
- Licensed Midwife
- Licensed Practical Nurse
- OB/GYN Nurse Practitioner
- Other Nurse
- Other Nurse Practitioner
- Pediatric Nurse Practitioner
- Registered Nurse
- School Nurse Practitioner
- Substitutes/Temporaries
- Volunteers

111.600 SOCIAL SERVICE PROVIDERS

- Caseworker
- Licensed Clinical Social Worker (L.C.S.W.)
- Licensed Social Worker (L.S.W.)
- Counselor
- Counselor (M.S.)
- Social Worker (B.S.W.)
- Social Worker (M.S.W.)
- Substitutes/Temporaries
- Volunteers

SCHEDULE A - CHART OF ACCOUNT CODES (CONTINUED)

111.700 NUTRITIONISTS/DIETITIANS

Dietitian (R.D. Eligible)	Registered Dietitian
Nutrition Educator	Substitutes/Temporaries
Nutritionist (Master Degree)	Volunteers

111.800 MEDICAL/DENTAL/PROJECT DIRECTOR

Dental Director	Project Director
Medical Director	

111.825 PROJECT COORDINATOR

111.850 OTHER ADMINISTRATION

Accountant/Finance/Bookkeeper	Laboratory Technician
Administrator/General Manager	Maintenance/Housekeeping
Clinic Aide	Nurse Aide
Clinic Coordinator (Administration)	Other Administration
Communications Coordinator	Programmer/Systems Analyst
Data Entry Clerk	Secretary/Clerk/Medical Record
Evaluator	Substitutes/Temporaries
Genetic Associate/Assistant	Volunteers
Laboratory Assistant	

115.000 FRINGE BENEFITS

200.700 TRAVEL

Conference Registrations	Out-of-State Staff Travel (only available with non-matching funds)
In-State Staff Travel	

200.800 RENTAL AND UTILITIES

Janitorial Services	Rental of Space
Other Rentals	Utilities
Rental of Equipment and Furniture	

200.850 COMMUNICATIONS

Postage (including UPS)	Reports
Printing Costs	Subscriptions
Publications	Telephone

200.900 OTHER EXPENDITURES

Insurance and Bonding	Insurance premiums for fire, theft, liability, fidelity bonds, etc. Malpractice insurance premiums cannot be paid with grant funds. However, matching and nonmatching funds can be used.
Maintenance and Repair	Maintenance and repair services for equipment, furniture, vehicles, and/or facilities used by the project.
Other	Approved items not otherwise classified above.

EXAMPLES OF EXPENDITURE ITEMS THAT WILL NOT BE ALLOWED

The following may not be claimed as project cost for MCH and CSHCN projects and may not be paid for with TITLE V or TITLE V Matching Funds:

1. Construction of buildings, building renovations;
2. Depreciation of existing buildings or equipment;
3. Contributions, gifts, donations;
4. Entertainment, food;
5. Automobile purchase;
6. Interest and other financial costs;
7. Costs for in-hospital patient care;
8. Fines and penalties;
9. Fees for health services;
10. Accounting expenses for government agencies;
11. Bad debts;
12. Contingency funds;
13. Executive expenses (car rental, car phone, entertainment);
14. Client travel; and
15. Legislative lobbying.
16. Out-Of-State Travel
17. Dues to societies, organizations, or federations.

For further clarification on allowable expenditures please contact:
Alisha Borcherding, MCH Business Manager,
ABorcherding@isdh.in.gov or *317/233-7129*

SECTION 7: REQUIRED ATTACHMENTS

SECTION 7-A. BIOSKETCHES (INSTRUCTIONS)

Please use the **TITLE V APPLICATION** document, Section 7-A to fill out the required BioSketch information.

For position already filled, provide a brief BioSketch for five key personnel (note: more than five may be listed, but please include only five BioSketches.

SECTION 7-B. JOB DESCRIPTIONS (INSTRUCTIONS)

Please use the **TITLE V APPLICATION** document, Section 7-B to fill out the required Job Description information.

For position to be announced and positions currently filled, please provide a brief Job Description for up to five key personnel to be hired (note: more than five may be hired, but please include only five Job Descriptions).

SECTION 7-C. TIMELINE (INSTRUCTIONS)

Please use the **TITLE V APPLICATION** document, Section 7-C to fill out the required Timeline information.

List activities to occur within each of the Phases (Planning, Implementation, Evaluation)

Indicate in which quarter(s) each activity will occur

Please ensure these activities and dates of occurrence correspond with the activities and dates listed in the activities narrative of **TITLE V APPLICATION** document, Section 5-D.

SECTION 7-D. ACTION PLAN TABLES (INSTRUCTIONS)

Please use the **TITLE V APPLICATION** document, Section 7-D to fill out the required Action Plan Tables.

Review to the Action Plan Tables listed in this TITLE V FOA for the recommendations of (1) Priority Measures; (2) Activities; and (3) Measurable Outcomes. Use this list as *recommendations* for the selected Priority Area(s) you choose to address.

Please ensure that each Priority Measure you wish to address has at least three, but no more than five *major* Activities with associated Measurable Outcomes. (Additional activities can be conducted; however, please only list a maximum of five *major* Activities).

This information provided in the Action Plan Tables must match the detailed information provided in the **TITLE V APPLICATION** document, Section 7-D Outcome Forms.

Five application plan tables are available, one for each of the Service Categories. However, grantees are NOT required to select all five Service Categories, and therefore NOT required to fill out each Action Plan Table. Please choose the Action Plan Table(s) that apply to your proposed project.

Please type "N/A" into the boxes for Activities and Measurable Outcomes *not applicable* to your proposed project.

SECTION 7-E. OUTCOME FORMS (INSTRUCTIONS)

Please use the **TITLE V APPLICATION** document, Section 7-E to fill out the required Outcome Forms.

In the top line, labeled "Service Category," insert the proposed project's first Service Category (Pregnant Women/Infants, Children, Adolescents, Women of Childbearing Age, and Children & Youth with Special Health care Needs).

[If your project proposes to address more than one service category, additional boxes are available for completion].

In the second line, labeled "Priority Area," insert the proposed project's first Priority Area for the corresponding Service Category (as listed in Section 7-D Action Table Plan).

In the third line, labeled "Activity," insert the first activity for the corresponding Priority Area (this activity should match what is listed in Section 7-D Action Table Plan).

In the rows labeled "Outcome 1, 2, 3, & 4," insert measurable outcomes for each corresponding Activity. Each activity can have up to four measurable outcomes. If your activity has more than four, please select your top four outcomes.

In the columns labeled by Quarter, please list the proposed project's *Expected* quantitative outcome to be achieved for each Outcome. The *Actual* outcomes will be submitted following each previous quarter (on a quarterly basis).

- The *Expected* results must be measurable and quantitative. These figures will serve as the success indicators for your project.

- Examples include: educate 100 women; disseminate 300 educational materials; increase percent of women with a child-spacing of 18 months or greater.

EXAMPLE of Completed Outcome Forms^:

Service Category: Women of Childbearing Age (14-44)

Priority Area written as SMART Objective: By October 1, 2012, increase the percent of women who, at their women-woman check-ups / annual visits, report quitting and abstaining from tobacco during the last 6 months by 10%. [Original SPA = reduce the number of pregnant women on Medicaid who smoke].

ACTIVITY: Smoking cessation education, counseling, referral and/or interventions to prevent use.	**1st Quarter**		**2nd Quarter**		**3rd Quarter**		**4th Quarter**	
	Expected	Actual	Expected	Actual	Expected	Actual	Expected	Actual
Outcome 1: # enrolled in program	0		75		90		100	
Outcome 2: # counseled / referred	0		75		90		100	
Outcome 3: # of women who quit smoking	0		20		25		30	
Outcome 4: # of women who remained tobacco-free at follow up	0		N/A		N/A		10	

Service Category: Pregnant Women and Infants (0-1)

Priority Area written as SMART Objective: By October 1, 2012, increase the percent of women who, at delivery, report abstaining from tobacco during pregnancy by 10%. [Original SPA = reduce the number of pregnant women on Medicaid who smoke].

ACTIVITY: Smoking cessation education, counseling, referral and/or interventions to prevent use.	**1st Quarter**		**2nd Quarter**		**3rd Quarter**		**4th Quarter**	
	Expected	Actual	Expected	Actual	Expected	Actual	Expected	Actual
Outcome 1: # enrolled in program	0		75		90		100	
Outcome 2: # counseled / referred	0		75		90		100	
Outcome 3: # of women who quit smoking during pregnancy	0		20		25		30	
Outcome 4: # of women who remained tobacco-free after pregnancy at follow up	0		N/A		N/A		10	

^Note that in each example above, the Service Categories were different. However, the original SPA was the same (reduce the number of pregnant women on Medicaid who smoke). The main difference is the way in which the Priority Area was written as a SMART Objective, which indicated one was for women preconceptually or interconceptually and the other was for women during pregnancy. The activities (or selected interventions) could have been the same or different for each of the examples, as the difference lies in the target population's phase (preconception / interconception vs. pregnancy).

SECTION 8: ADDITIONAL REQUIRED DOCUMENTS

If applicable, please include with the submission of the **TITLE V APPLICATION** document, the following required documents in your application submission (no specific format required).

Please mail an original and 4 copies of all supplemental to:

Division of Maternal and Child Health
c/o Theresa Hunter, Title V Program Liaison
2 N. Meridian St.
Indianapolis, IN 46204

*To ensure that your mailed supplemental materials are matched to your application, please write on the outside of the envelope your organization name, program name, and contact information.

Please refer to the SUBMISSION INFORMATION section for more information.

SECTION 8-A: IRS NONPROFIT TAX DETERMINATION LETTER (1 PAGE MAX)

If applicable, please include with the submission of the **TITLE V APPLICATION** document, a copy of the applicant organization's IRS Nonprofit Tax Determination Letter. Please limit this to 1 page total.

8-B: ORG CHART & PROGRAM-SPECIFIC ORG CHART (2 PAGES MAX)

Please include with the submission of the **TITLE V APPLICATION** document, a copy of the applicant organization's overall organizational chart as well as the applicant organization's program-specific organization chart. The program specific- organization chart must include program partners, existing program staff, to-be- hired program staff, key personnel, etc. Please limit this to 2 pages total.

8-C: LETTERS OF SUPPORT / AGREEMENT (10 PAGES MAX)

Please include with the submission of the **TITLE V APPLICATION** document, a copy of letters of support, letters of agreement, and/or memoranda of understanding. The letters of support and/or agreement must include date, contact information of individual endorsing letter, and involvement with the project or organization. Please limit this to 10 pages total.

Description of Service Categories & Action Plan Recommendations

Pregnant Women / Infants 0-1
Children 1-9
Adolescents 10-24
Women of Childbearing Age 14-44
Family Planning
Children & Youth with Special Health Care Needs Age 0-21

DESCRIPTIONS OF SERVICE CATEGORIES

The descriptions below contain background information regarding statistics and current data for each of the Service Categories. The issues mentioned were identified during the state-wide five-year Needs Assessment completed by MCSHCS staff and contribute to the overall health of a women and children.

Note: In 2007, Indiana started using the revised birth certificate (2003 version), which had different questions about prenatal care in the first trimester, making straightforward comparisons to previous years impossible. Indiana was notified in June of 2009 by the Centers for Disease Control and Prevention, National Center for Health Statistics (NCHS) that the state would see decreases in the percent of mothers receiving prenatal care in the first trimester, and that these changes had been observed in every state using the revised birth certificate. Indiana was informed to use 2007 as a new baseline going forward. The NCHS official position is that the data provided by the 1989 (unrevised) and 2003 (revised) birth certificates are not comparable. The 2007 data shows that only 67.5% of Indiana mothers are receiving prenatal care in the first trimester, 69.4% for white, 53.4% for black and 49.5% for Hispanic. These percentages will be the new baselines moving forward with the revised birth certificate.

DESCRIPTION OF PREGNANT WOMEN / INFANTS 0-1

Pregnant Women

SPA#2 (breastfeed): Increase the percentage of women who initiate exclusive breastfeeding for three months and continue to breastfeed for six months

Breastfeeding provides optimal nutrition for infants along with superior immune system, physical and cognitive development. Human milk is easily digested and contains antibodies that protect infants from bacterial, viral and other infections and also reduces the infant's later risk of overweight/obesity. In mothers, breastfeeding decreases the risk of postpartum hemorrhage and provides many positive physical and emotional benefits. The Healthy People 2020 website has many breastfeeding objectives.

In 2006, Indiana did not meet the 5 major Healthy People 2010 breastfeeding objectives and also fell below the national average. Indiana has shown a steady increase in the rate of mothers who ever breastfed their infants between 1990 and 2007. In 1990, less than half of new mothers (47.2%) breastfed their infants. In 2007, the rate grew to 67.1 percent. The rate of black mothers who ever breastfed their infants grew from 34.5% in 1990 to 47.6% in 2007.

SPA#4 (perinatal care): Increase the percent of women (especially black women) with a live birth whose prenatal visits were adequate

The objective of prenatal care within the first trimester is to monitor the health of the mother and fetus as early as possible. In Indiana, from 2002 through 2006, there has been a decline in the percentage of women who have received prenatal care within the first trimester each year in all races and ethnicities. In Indiana, the overall percentage dropped from 80.6% in 2003 to 77.6% in 2006. The percentage for whites decreased from 82.1% in 2003 to 79.2% in 2006 while the percentage for blacks decreased from 68.2% in 2003 to 65.6 % in 2006. The Hispanic population actually alternated between increases and decreases each year, but in 2006 was lower (62.8%) than the percentage in 2003 (64.6%).

SPA#3 (smoking): Reduce smoking among all women of childbearing age / Decrease the percent of women on who smoke (especially on Medicaid)

Another problem Indiana is facing is **smoking among women of childbearing age** (14-44 years old). Even though the rates have been decreasing since 2001, Indiana remains consistently higher than the rest of the United States. Indiana's rates peaked in 2001 at 33.6% and have since steadily decreased to 26.8% in 2007. The US percentage in 2007 was much lower at 21.2% of women smoking between the ages of 18 and 44. Smoking during pregnancy increases the risk for both a preterm

delivery as well as a low birth weight baby. It has also been linked to congenital abnormalities in the infant as well as placental problems for the mother. Indiana has shown a decreasing trend in the percentage of women who smoke between 2003 and 2007, before slightly increasing. Another population that has a high smoking rate is pregnant women on Medicaid. This is alarming since 51% of pregnant women in Indiana were on Medicaid in 2007. The majority of counties (68 out of 92) have 30% or more women [on Medicaid] attesting to smoking during pregnancy in 2007. The overall percentage of women on Medicaid who smoked during pregnancy was 27 percent, compared to 17.3% for all pregnant women in Indiana.

SPA#8 (obesity): Decrease the percent of those who are obese

Prevalence of gestational diabetes (GDM) has fluctuated over the 2006-08 time period but both blacks and Hispanics have seen an increase during 2008. This is a concern since having gestational diabetes increases the risk of developing diabetes later in life. Women who are diagnosed with gestational diabetes have a 20% to 50% chance of developing diabetes in the next 5 to 10 years. Black, Hispanic, and American Indian females are at greater risk of developing gestational diabetes than white females.

Global data also estimate a threefold increased risk of the mothers developing diabetes later in life and eightfold increased risk of the offspring developing diabetes or pre-diabetes by ages 19 to 27. US data estimate a 15% to 50% increased risk of a woman developing diabetes later in life, if she has a history of GDM.

The primary immediate risk from uncontrolled GDM for both mother and child results from a tendency for the baby to be large for gestational age (macrosomia). This leads to increased difficulty with delivery due to the large size, and increased risk of complications to both mother and child, including physical trauma during the birth process.

Infants

Prevention and early detection of problems in infants reduce the financial, personal and emotional burdens associated with adverse outcomes, such as infant mortality. The Infant Mortality Rate (IMR) per 1000 in Indiana showed an increase in 2004 to 8.1 from 2003 (7.4) and stayed steady through 2006. In 2007 the IMR decreased to 7.5 in Indiana. The white IMR in Indiana increased between 2003 and 2005 moving from 6.4 up to 6.9, and then decreased back down to 6.5 in 2007. The black IMR in Indiana constantly increased every year, from 15.9 in 2003 to 18.1 in 2006, before decreasing down to 15.7 in 2007. The Hispanic IMR in Indiana fluctuated every year between 2003 and 2007, peaking at 9.0 in 2004 and dropping to as low as 5.2 in 2006, but then increasing to 6.8 in 2007.

SPA# 1 (SIDS / SUIDS): Decrease rate of suffocation deaths in infants

An analysis was conducted to understand Indiana's sudden unexplained infant deaths (SUIDs) including sudden infant death syndrome (SIDS), other SUIDs (accidental suffocation and strangulation, intent unknown suffocation, neglect, abandonment, and maltreatment syndromes), and deaths of unknown cause. Between 1990 and 1998, as SIDS rates declined in Indiana, so did rates due to combined SIDS, other SUIDs, and unknown cause. After 1998, SIDS rates continued to decline. However, the combined rates of SIDS, other SUIDs, and unknown cause did not decline. During the 1995-1998 and 1999-2002 periods, the SIDS rate in Indiana declined by 39%whereas rates for unknown cause and accidental suffocation increased by 67 and 106 percents, respectively.

SPA#7 (prematurity): Decrease the percent of preterm births

Premature birth (37 weeks and under) is defined as birth prior to at least three weeks before full term birth (40 weeks). Prematurity is the leading cause of death among newborn babies. Being born premature is also a serious health risk for a baby and can require special care and possible time hospitalized in a neonatal intensive care unit (NICU). Those who survive may face lifelong problems such as intellectual disabilities, cerebral palsy, breathing and respiratory problems, vision and hearing loss, and feeding and digestive problems.

Indiana has slightly increased in percentage of premature births between 1997 (11%) up until 2005 (13.5%), before starting to decrease in 2006 (13.2%) and 2007 (12.9%). The black premature birth rate in Indiana between 2000 and 2005 has consistently increased, and is at a much higher percentage than the total premature percentage. From 2000 through 2002, the black premature birth percentage was 18.1, before increasing to 18.5 between 2003 through 2005.

NPA#17 (low birthweight): Increase the percent of very low birthweight infants delivered at facilities for high risk deliveries and neonates

Indiana has shown an increase in low birthweight (infants born less than 2500 grams) over the past 5 years. In 2003, the percentage of babies born low birthweight was 7.9%, but then steadily increased up to 8.3% in 2005 before increasing more to 8.5% in 2007. The white population shows the same trend as the total, increasing from 7.2% in 2003 up to 7.6% in 2005 before increasing more to 7.8% in 2007. At this rate, Indiana will not meet the national goal of 5%. The black low birthweight percentages have steadily increased every year from 13.3% in 2003 up to 14.4% in 2007. The Hispanic rate also has steadily increased from 5.9% in 2003 slightly up to 7.2% in 2007. Neither the black or Hispanic population will meet the Healthy People 2010 goal of 5% at these trends.

RECOMMENDATIONS FOR ACTION PLAN: PREGNANT WOMEN / INFANTS 0-1

The Action Plan below provides recommended activities and measurable outcomes for each priority area within the specified service category. These are RECOMMENDED EXAMPLES of priority measures, activities, and outcomes a program can address. Please choose the activities and correlated measurable outcomes based on your organization's selected priority measures.

Recommendations for Action Plan: Pregnant Women / Infants 0-1		
Priority Measures	**Recommended Activities**	**Measurable Outcomes**
SPA#2 (breastfeed): Increase the percentage of women who initiate exclusive breastfeeding for three months and continue to breastfeed for six months	Primary and tertiary care interventions to promote breastfeeding, i.e., patient education, community based peer counselors, support groups, community education, parish nurses. Implementation of neighborhood based peer counselors or mentors.	Measure number of pregnant women receiving breastfeeding assessment and education in first and third trimester. Measure number of women breastfeeding at time of hospital discharge, and at time of post partum assessment. Describe success of Intervention provided, such number reached through intervention, number completing the intervention, follow up done, health behavior changes, i.e., increased knowledge, increase breastfeeding rates of target population, increase in prolonged exclusive breastfeeding
SPA#4 (perinatal care): Increase the percent of women (especially black women) with a live birth whose prenatal visits were adequate	Community outreach, free pregnancy test program to identify pregnant women early and facilitate entrance into prenatal care Home visiting case management Use of patient navigators/community health advocates, baby first advocates, Community based doulas for support to assure all medical appointments accessible and kept. Centering pregnancy Participation in presumptive eligibility Use of life-course, social determinants assessment and interventions Cultural competency training Population based/neighborhood based consumer education i.e., Folic Acid, ―How to have a Healthy pregnancy‖, –I Want My 9 Months‖, –It's worth the wait‖, ―Quit for Two‖, or –A Healthy Baby Depends on You‖ in collaboration with community minority health groups, churches, community centers, other community agencies. Connecting Those at Risk to Care community HUB	Demonstrate success of outreach activities provided. Analyze success of home visiting program. Demonstrate participation in presumptive eligibility. Compare results of use of patient support initiatives to those not receiving support. Measure success of community consumer education programs. Summarize successes of building a community HUB.

	manual. Implement Pathways collaborative community model. (The Agency for Health care Research and Quality (AHRQ) has released a new guide titled: Connecting Those at Risk to Care: A Guide to Building a Community ―Hub‖ To Promote Collaboration, Accountability, and Improved Outcomes.	
SPA#3 (smoking): Reduce smoking among all women of childbearing age / Decrease the percent of women who are pregnant who smoke (especially on Medicaid)	Ask clients if they smoke at time of enrollment and document smoking in chart. Monitor all clients at each visit for smoking status Educate clients at time of enrollment and provide education hazards of smoking Referral women identified as smoking at time of enrollment / refer women to the Indiana Tobacco Quitline	# of newly enrolled clients with documented smoking status each quarter # of charts with documented smoking status per visit each quarter # of unduplicated smoking clients per quarter # of women identified as smokers at time of enrollment who receive education on the hazards of smoking # of clients referred to the Indiana Tobacco Quitline. # clients who state they are smoking at time of enrollment
SPA#8 (obesity): Decrease the percent of those who are obese	Calculate BMI for each client and discuss impact/risk of high BMI (> 30) on pregnancy outcomes Chart/track pregnancy weight gain on pregnancy weight gain grid Assess BMI at time of enrollment Assess readiness to change Transtheoretical model. Plan and structure intervention based on client's location on stages of change model Provide Nutrition Intervention that addresses diet, physical activity, and behavioral issues Personal goal-setting contracts. Long-term follow-up coaching on individual Document follow-up/on-going activities	Number of clients enrolled Number of clients retained #of enrolled clients during quarter #of clients with BMI documented. # of clients with BMI over 29 who receive brief intervention and/or treatment during the quarter # of clients with BMI over 29 during the quarter BMI level on entrance into program (e.g. Class I through Class III obesity). Stage of Change Level on entrance Attendance of sessions (individual/class). Percent of women achieving of personal goals contracts. Number of women receiving long-term follow-up Proportion of participants with a Body Mass index indicating overweight or obesity who have received healthy weight counseling and/or other related interventions or treatment
SPA#1 (SUIDS / SIDS): Decrease rate of suffocation deaths in infants	Bedtime Basics safe sleep education to all parents during pregnancy and postpartum encounters. Referral to First Candle Crib program Fetal infant mortality review Hospital L&D Unit implements the NIH national training of professional staff ―Model Behavior‖,	Compare actual results of Bedtime Basics education to expected results. Demonstrate completion of referrals. Analyze results of infant death

	assures every mother views the –Safe Sleep For Babies‖ video prior to hospital discharge	reviews. Describe Staff knowledge acquisition Documentation of parent education prior to hospital discharge.
SPA#7 (prematurity): Decrease the percent of preterm births	Use of 17-alpha hydroxyl progesterone for pregnant women with prior spontaneous preterm birth Screening and brief intervention to reduce alcohol and drug use Home visiting case management. Obesity prevention and control through diet and exercise to achieve normal BMI, assure appropriate weight is gained in pregnancy	Number of pregnant patients with a previous preterm delivery offered 17-alpha hydroxyl progesterone. Number of patients who complete a course of 17-alpha hydroxyl progesterone. Birth outcome of those patients receiving and not receiving 17-alpha hydroxyl progesterone. Number of pregnant patients screened for ATOD, number positive, number receiving brief intervention, and referral. Number of pregnant women assessed as high risk for preterm birth that were referred for home visiting case management. Percent of infants born at normal gestation and birthweight.
NPA#17 (low birthweight): Increase the percent of very low birthweight infants delivered at facilities for high risk deliveries and neonates	Risk screening of all pregnant women at first encounter. Early entrance into prenatal care Case management or prenatal care coordination (PNCC) Referral to OB specialist	Demonstrate knowledge of causes of very low birthweight through interventions provided.

DESCRIPTION OF CHILDREN 1-9

Description of Priority Areas

SPA#5 (lead poisoning): Decrease the percent of children less than 72 months of age with blood lead levels equal to or greater than 10 micrograms per deciliter

Lead poisoning is a silent menace which often does not manifest itself until the damage is done. The condition can permanently and irreversibly damage the developing brains and other organs of young children. Serious effects can include lowered intelligence, behavior disorder, and slowed physical development. Once poisoned, a young child's chances for academic, social and occupational success are significantly diminished. A child with one venous blood specimen ≥10 g/dL, or any combination of two capillary and/or unknown blood specimens ≥10 g/dL drawn within 12 weeks of each other is confirmed for elevated blood lead level (EBLL). The number of Indiana children under seven years old who were tested for lead increased by 13,751 (26%) in calendar year 2007. As a result of increased testing, the number of children confirmed as lead-poisoned has also increased to 656 (13.5%). Since 2000, 336,519 children have been tested. Of those, 4,514 have been confirmed with elevated blood lead levels.

SPA#10 (social/emotional health): Build capacity for promoting social and emotional health in children birth to age 5

Young children, under the age of five are becoming a particular area of concern with respect to abuse and neglect. This unique population is not tracked via any school system report and thus is likely to exist under the radar in regards to their needs for social, emotional and mental health intervention. Early childhood exposure to abuse, *neglect, traumatic experiences and high-risk environments can have a life-long impact.*

NPA#14 (obesity): Decrease the percent of children, ages 2-5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile

In the United States, being overweight or obese is a problem among all stages of the human lifecycle, beginning with infancy and continuing to late adulthood. For Indiana children under the age of 5, data are not available for overweight and obesity other than what is collected through the Centers for Disease Control and Prevention (CDC) Pediatric Nutrition and Surveillance System (PedNSS). These data evaluate health parameters of participants only in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and do not represent the state population as a whole. The 2009 PedNSS results for Indiana show that the weight trends of children aged 2-5 closely mirror national trends. From 1999 to 2009, overweight and obesity in Indiana for children aged 2-5 increased slightly from 15% to 17% and 12% to 14%, respectively. Nationwide, during this same timeframe, the same increase (15% to 17%) was noted for overweight in children aged 2-5; however, obesity was slightly higher, going from 13% to 15%.

NPA#9 (sealants): Increase the percent of third grade children who received protective sealants on at least one permanent molar tooth

The National Performance Measure #9 for the Indiana Maternal and Child Health MCH Block Grant has historically been: Percent of third grade children who have received protective sealants on as least one permanent molar. The CDC has published the Healthy People 2020 Summary of Objectives for Oral Health: Objective OH-12.2 Increase the proportion of children aged 6 to 9 years who have received dental sealants on one or more of their permanent first molars. Some public health organizations request data by grade, and some request data by age. The Oral Health Program at the ISDH prefers to collect data by age for several reasons, some scientific and some pragmatic. The pragmatic reason to collect data by age is that most of the programs do not routinely request that patients designate grade during their dental visits. If required to report data for third graders, simply combine data for 8 and 9 year old children as a proxy measurement for data for third graders.

NPA#7 (immunizations): Increase the percent of 19-35 months old who have received a full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilis Influenza, Hepatitis B

In November each year, the ISDH Immunization program collects immunization data from schools across Indiana. In the 2006-07 school year, data were collected from 1833 schools in Indiana. Data collection included information on 255,346 kindergarten, first grade, and sixth grade students. This covered over 85% of the schools in Indiana. Ninety-six percent of students enrolled at reporting schools completed the immunizations necessary according to state requirements. There was an increase of five percentage points from the previous assessment year. However, due to concerns of data validity with the reported immunization rates required by state law, the ISDH Immunization Program also conducts an annual validation survey. A total sample size of 136 schools was selected for validation. In the 136 schools selected, 36 validations included only kindergarten, 16 included only first grade, 33 included only sixth grade. Fifty-one percent of the validations included multiple grades. Overall, immunization rates increased 1.5 percentage points between the submission of the self-reported annual school assessment and the validation of immunization records in the selected schools. The immunization rate for kindergarten showed the most improvement between the self-reported assessment and the validation survey, increasing 4.6 percentage points. First grade immunization rates decreased 0.6 percentage points with the validation of records, while the immunization rate for sixth grade increased 0.6 percentage points within the same time interval.

NPA#13 (insurance): Decrease the percent of children without health insurance

In Indiana, there are 1,680,000 children under the age of 19 in Indiana. Of these children, about one in 10 (or 161,000) has no health insurance. In 2007, 7% of Indiana's children under the age of 6 were uninsured; 8% of Indiana's children

between the ages of 6 and 12 were uninsured; and 14% of children between the ages of 13 and 18 were uninsured. Forty eight percent of Indiana's uninsured children live in families with annual incomes at or below twice the federal poverty level (Families USA 2008). Additionally, based upon information in the Agency Claims and Administrative Processing System (ACAPS), almost 92% of the participants in Indiana's CSHCN program have either private or public health insurance while 46% of participants have some kind of private health insurance and 46% have Medicaid.

MCH grantees will serve as enrollment sites for Hoosier Healthwise and refer clients to local Hoosier Healthwise enrollment sites. Also, all MCH grantees providing primary care to children must be Medicaid providers.

Indiana's Early Childhood Comprehensive Systems grant, the Sunny Start: Healthy Bodies, Healthy Minds initiative includes strategies to increase the percentage of children who have health insurance. Twenty six financial resource fact sheets were developed for families including information on a variety of insurance options such as Medicaid and SCHIP enrollment may be found at www.earlychildhoodmeetingplace.org.

RECOMMENDATIONS FOR ACTION PLAN: CHILDREN 1 – 9

The Action Plan below provides recommended activities and measurable outcomes for each priority area within the specified service category. These are RECOMMENDED EXAMPLES of priority measures, activities, and outcomes a program can address. Please choose the activities and correlated measurable outcomes based on your organization's selected priority measures.

Recommendations for Action Plan: Children 1- 9		
Priority Areas	**Recommended Activities**	**Measurable Outcomes**
SPA#5 (lead poisoning): Decrease the percent of children less than 72 months of age with blood lead levels equal to or greater than 10 micrograms per deciliter	Order blood lead testing for children 9 -72 months of age Increase awareness and outreach efforts monitoring and disseminating product alerts from the Consumer Product Safety Commission bulletins and other sources regarding consumer product safety issues Continue efforts to increase the percent of Medicaid screened children by Medicaid reimbursement for testing and case management,	# of children screened through measurement of blood lead levels # of positive screens # referred to lead abatement program Outreach activities
SPA#10 (social/ emotional health): Build capacity for promoting social and emotional health in children birth to age 5	Encourage and educate those that work with young children to participate in the Michigan Association for Infant Mental Health (MI-AIMH) Endorsement, a set of competencies and a credentialing process in infant mental health	# of MI-AIMH endorsed providers per county Proportion of children under age 6 who receive behavioral screenings # of referrals for mental health consultation Proportion of mothers of children under age 6 screened and appropriately referred for depression
NPA#14 (obesity): Decrease the percent of children, ages 2-5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile	Screen for BMI ---Applies to ALL ages Practice nutrition intervention including education/referral Create educational materials for clientele (personal responsibility, information on strategies that work, family-centered activities). Consider using the INShape IN website or the IN Healthy Weight Initiative. Facilitate clinic and community involvement in physical activity promotion and obesity prevention activities	The number of children with BMIs at or above the 85th percentile. The number referred for Nutritional intervention The number referred for physical activity programming The number of educational programs provided Percentage of children with elevated BMI whose BMI's decreased over period of time.

NPA#9 (sealants): Increase the percent of third grade children who received protective sealants on at least one permanent molar tooth	Work with Indiana Medicaid to increase the number of children that receive dental sealants Work with Non-Medicaid Programs to increase the number of children that receive dental sealants	Proportion of children 8 and 9 years old seen during the FY, and presenting with no dental sealant on any permanent first molar, that had a dental sealant placed on at least one permanent first molar by the end of the FY. Proportion of children 8 and 9 years old seen during the FY that had a dental sealant on at least one permanent first molar by the end of the FY.
NPA#7 (immunizations): Increase the percent of 19-35 months old who have received a full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilis Influenza, Hepatitis B	Work with the Immunization Program to increase the number of MCH sites enrolled as Vaccine for Children (VFC) program and/or Children and Hoosiers Immunization Registry (CHIRP) providers Enroll patients in the CHIRP reminder/recall feature Consider possible participation in the VCF Assessment, Feedback, Incentives, eXchange (AFIX) visits to assess VFC policies (ISDH Immunization program) ublicize /distribute Sunny Start Educational materials	The number children enrolled in CHIRP The percentage of children who receive immunizations appropriate to their age and medical status Participation in WIC The number of Sunny Start educational materials distributed
NPA#13 (insurance): Decrease the percent of children without health insurance	If providing primary care to children, the site must be a Medicaid provider. Collaborate with the Indiana Office of Medicaid Policy and Planning (OMPP) to ensure access to health care and enrollment into HHW/HIP When appropriate, enroll children in CSHCN. Serve as enrollment site for Hoosier Healthwise or refer patients to local enrollment sites. Share Sunny Start resource fact sheets regarding health insurance enrollment opportunities such as private, public, Medicaid Waivers, Children with Special Health Care Needs, and SSI) at local health fairs, etc. Publicize and participate in the new About Special Kids (ASK) public health insurance training curriculum available to families and professionals	Number of children provided with primary care Percentage of children with health insurance he number of Sunny Start Fact Sheets distributed Number of eligible children enrolled in CSHCN Number of eligible children enrolled in Hoosier Healthwise The number of children enrolled in HHW/HIP, and CSHCN ASK public health insurance training provided and the number of participants

	Participate in Indiana Community Integrated Systems of Service (IN CISS) Medical Home Learning Collaborative where families, practice staff and physicians are trained on health care financing options for Children and Youth with Special Health Care Needs (CYSHCN).	

DESCRIPTION OF ADOLESCENTS 10 -24

Description of Priority Areas

NPA #16 (suicide): Decrease the rate (per 100,000) of suicide deaths among youths aged 15-19

According to the Indiana Youth Risk Behavior Survey from 2009, suicide attempts and planning attempts did not change between 2003 and 2009. There were 3.6% of students who indicated that they had made a suicide attempt that resulted in an injury, poisoning or overdose and had to be treated by a doctor or nurse compared to 1.6% during 2003, which was a significant increase. Fifteen percent of the total number of patients seen in an inpatient setting for self-inflicted injury was aged 10-19. Youths, ages 15-19, comprised 80% of these attempts. Sixty-eight percent of the self-inflicted injury attempts were by females and 77% were by whites. Blacks were responsible for 9% of the attempted suicides and all other races accounted for 14% of youth attempts.

NPA#8 (births to teens): Decrease the rate of births (per 100,000) for teenagers ages 15-17

An increase in sexual activity among adolescents and young people in Indiana and the United States has lead to an alarming number of teen pregnancies. Although the teen birth rate in both Indiana and the United States has declined significantly between the early 1990's and today, Hoosier adolescents are still at great risk for becoming pregnant or causing a pregnancy.

According to the National Campaign to Prevent Teen and Unplanned Pregnancy, had the teen birth rate in Indiana not declined 26%between 1991 and 2002, there would have been nearly 19,000 additional children born to teen mothers during those years. In 2002, there would have been nearly 5,800 more children in poverty and nearly 6,700 additional children living with a single mother.

The 2009 Youth Risk Behavior Survey (YRBS) data for Indiana reveal that 49.2% of students have ever had sexual intercourse; 36.7% have had sexual intercourse with one or more people during the past three months; and among students who have had sexual intercourse during the past three months, 58% used a condom during last sexual intercourse and 23.2% used birth control pills to prevent pregnancy.

The percentage of students who reported using a condom during their last sexual intercourse also did not change between 2003 and 2009 (55.4% to 58.0%). The 2009 YRBS data indicate that 4.5% of the students interviewed reported having their first sexual intercourse before the age of 13. In addition, 21.0% reported using drugs or alcohol before their last sexual intercourse. About 1 in 4 students reported using birth control pills before their last sexual intercourse. Approximately 14% of students reported having four or more sexual partners in their lifetime. In Indiana in

2006, approximately 11% of the births to residents were by youth age 19 and under. This percent is slightly down from 2005. This number has been decreasing since 1996.

SPA#8 (obesity): Decrease the percent of those who are obese

The overall goal outlined in Healthy People 2010 is to decrease the proportion of overweight 9th through 12th graders from 11 to 5 percent. The 2009 Youth Risk Behavior Survey YRBS (http://www.in.gov/isdh/20627.htm), for grades nine through twelve, looked at key areas which contribute to weight and nutrition. One key area of concern is overweight and obese children. In youth, obesity is linked to high blood pressure, type 2 diabetes, and high cholesterol. Obesity can also lead to coronary heart disease later in life. In the 2009 YRBS report for Indiana, 12.8% of youth reported they are obese (at or above the 95th percentile for their age, sex and BMI), which is down from 15% in 2005. The data show that 15.9% of youth are overweight (between 85th and 94th percentile), which is a full percent and a half higher than in 2005, 14.3%.

SPA#9 (STIs): Decrease the percent of high school students who become infected with STIs

Every year one out of four sexually active teens becomes infected with a sexually transmitted infection (STI) in the US. In 2009, one out of every three Chlamydia cases in Indiana was someone under the age of 19. One out of four cases of Gonorrhea was someone under 19. In 2009, females had 75% of the Chlamydia cases and about 58% of the Gonorrhea cases. Black non-Hispanics were more likely to have Chlamydia and Gonorrhea in 2009 than white non-Hispanics. The emerging adult population of ages 20-24 had the most cases of Chlamydia and Gonorrhea in Indiana in 2009. The younger an individual initiates sexual intercourse, the more likely they are to have more lifetime sexual partners, the higher the risk of pregnancy, and the lower the chances of using contraception. In Indiana, the percentage of high school students who reported ever having sex did not significantly change between 2003 and 2009 (48.8% to 49.2%).

RECOMMENDATIONS FOR ACTION PLAN: ADOLESCENTS 10 – 24

The Action Plan below provides recommended activities and measurable outcomes for each priority area within the specified service category. These are RECOMMENDED EXAMPLES of priority measures, activities, and outcomes a program can address. Please choose the activities and correlated measurable outcomes based on your organization's selected priority measure.

Recommendations for Action Plan: Adolescents 10-24		
Priority Areas	**Recommended Activities**	**Measurable Outcomes**
NPA #16 (suicide): Decrease the rate (per 100,000) of suicide deaths among youths aged 15-19	Train persons in youth serving organizations to identify and refer youth at risk for suicide Promote the National Suicide Prevention Lifeline Implement evidence-based suicide prevention programs for young people (may refer to the resources for evidence-based programs found on the Substance Abuse and Mental Health Services Administration 's website) Develop, implement and evaluate a mental health awareness campaign Partner with school nurse/clinic to administer a risk assessment survey to students and identify those who have suicidal thoughts/ideation.	Number of individuals trained to recognize the signs of suicide and refer young people for help if suicidal Number of brochures, educational materials, promotional items disseminated to students Number of young people who received evidence-based suicide prevention program Number of screenings conducted on young people for suicidal risk by school nurse or clinic Number of follow-up visits/referrals with students who have been identified as "at risk"
NPA#8 (births to teens): Decrease the rate of births (per 100,000) for teenagers ages 15-17	Collaborate with schools to ensure the implementation of evidence based sexual health programs Involve the community in discussions of what it wants and need from adolescent sexual health programs Create and/or market venue (website, social media page, hotline) for adolescents to easily access accurate sexual health information Health education on HIV, STD, life style behaviors,	Number/percentage of students who have ever had sexual intercourse Number/percentage of students using condoms (or contraceptive use) during last sexual intercourse Change in students' knowledge around sexual health following program Number of teen births in a school following the implementation of evidence based program Number of births (per 100,000) for teenagers ages 15-17 Number accessing created/marketed venue (website, social media page, hotline)

	healthy habits, contraception choices, abstinence Assess all clients for contraception method problems at time of method pick-up/exam.	
SPA#8 (obesity): Decrease the percent of those who are obese	Screen for BMI ---Applies to ALL ages Practice nutrition intervention including education/referral Create educational materials for clientele (personal responsibility, information on strategies that work, family-centered activities). Consider using the INShape IN website or the IN Healthy Weight Initiative. Facilitate clinic and community involvement in physical activity promotion and obesity prevention activities	The number of children with BMIs at or above the 85th percentile. The number referred for Nutritional intervention The number referred for physical activity programming The number of educational programs provided Percentage of children with elevated BMI whose BMI's decreased over period of time.
SPA#9 (STIs): Decrease the percent of high school students who become infected with STIs	Collaborate with schools to ensure the implementation of evidence based sexual health programs Involve the community in discussions of what it wants and need from adolescent sexual health programs Create and/or market venue (website, social media page, hotline) for adolescents to easily access accurate sexual health information Health education on HIV, STD, life style behaviors, healthy habits, contraception choices, abstinence Assess all clients for contraception method problems at time of method pick-up/exam Provide testing for STIs, specifically gonorrhea and Chlamydia, among clients	Number/percentage of students who have ever had sexual intercourse Number/percentage of students using condoms (or contraceptive use) during last sexual intercourse Number/percentage of students who have ever been taught about AIDS or HIV infection in schools Number of clients with a positive test for gonorrhea or Chlamydia who receive treatment

DESCRIPTION OF WOMEN OF CHILDBEARING AGE 14-44

SPA#6 (birth spacing): Decrease the percent of births that occur within 18 months of previous birth to the same birth mother

Short interpregnancy interval is defined as less than 12 completed months between the last live birth and conception. According to a John Hopkins' report and the International Journal of Gynecology & Obstetrics, babies born after a short interpregnancy interval are at greater risk of low birthweight. Since the early 1990_s, the percentage of Indiana births following a short interpregnancy interval of less than 12 months declined by 14 percent, from 21.1 to 18.3 percent. In the 2002-2005 period, 9.2%of non-Hispanic black multiparous mothers had an interpregnancy interval of less than 6 months compared to 5.5 and 6.9%among their non-Hispanic white and Hispanic counterparts, respectively. According to the Pregnancy Nutrition Surveillance System (PNSS) which, in Indiana, is collected during prenatal WIC visits, Indiana has had higher rates of short interpregnancy interval compared to the US over the 3 years (2004-2006). Considering the adverse effect of short interpregnancy intervals of up to 12 months on birth outcomes, efforts of public health agencies to improve birth spacing should continue beyond 6 months postpartum, especially in those high risk populations such as non-Hispanic blacks, Hispanics, the young, unmarried and uneducated mothers.

FPA #2 (preconception /interconception health): Increase number of women receiving preconception counseling prior to pregnancy

According to the CDC, —by age 25 years, approximately half of all women in the United States have experienced at least one birth, and approximately 85% of all women in the United States have given birth by age 44 years.‖ Although 84% of women of childbearing age had a health care visit within the last year, as the CDC reports, only one in six OB/GYNs or family physicians provided preconception care to the majority of women for whom they provided prenatal care. These statistics indicate that while the majority of women can expect to become a mother, very few can expect to receive any preconception or interconception counseling.

The CDC notes that –improving preconception health can result in improved reproductive health outcomes, with potential for reducing societal costs as well. Preconception care aims to promote the health of women of reproductive age before conception and thereby improve pregnancy-related outcomes.‖ The recommendations for preconception care from the CDC include:

1) Individual responsibility across the lifespan
2) Consumer awareness
3) Preventive visits
4) Interventions for identified risks
5) Interconception care
6) Pre-pregnancy checkup

7) Health insurance coverage for women with low income
8) Public health programs and strategies
9) Research
10) Monitoring improvements.

The primary goal of preconception and interconception care is to promote, screen, and provide services and programs for women of childbearing age to reduce risks that may influence forthcoming pregnancies and deliveries. Providing some form of interconception health to every single woman seen for primary, secondary, or even tertiary care can aid physicians in identifying and treating conditions that can lead to healthier mothers and babies.

While multiple components are important for preconception and interconception health, please note the CDC reports that –the best evidence for the effectiveness of these specific components of preconception care has been documented when the focus of delivery was on a single risk behavior and accompanying intervention, rather than delivery of multiple interventions.‖

FPA #1 (unintended pregnancies): Reduce unintended pregnancy among women of childbearing age

The CDC states that –an unintended pregnancy is a pregnancy that is either mistimed or unwanted at the time of conception. Unintended pregnancy is associated with an increased risk of morbidity for women, and with health behaviors during pregnancy that are associated with adverse effects.‖ Nationally, almost half of all pregnancies are unintended. Several safe and highly effective methods of contraception (birth control) are available to prevent unintended pregnancy. However, organizations must take a proactive role in helping women to increase effective contraceptive use and adherence.

According to the Guttmacher Institute, nationally, –the rate of unintended pregnancy in 2001 was substantially above average among women aged 18–24, unmarried (particularly cohabiting) women, low-income women, women who had not completed high school and minority women. Between 1994 and 2001, the rate of unintended pregnancy declined among adolescents, college graduates and the wealthiest women, but increased among poor and less educated women. The abortion rate and the proportion of unintended pregnancies ending in abortion among all women declined, while the unintended birth rate increased. Forty-eight percent of unintended conceptions in 2001 occurred during a month when contraceptives were used, compared with 51% in 1994.

Unintended pregnancies are associated with several negative consequences, including: (1) women are less likely to obtain adequate prenatal care in the first

trimester; (2) women are more likely to continue to use alcohol and tobacco during pregnancy; (3) women who are already in a relationship involving physical abuse may be at greater risk with her partner; (4) women are more likely to have or seek an abortion; and (5) infants and children born to women with unplanned pregnancies are at greater risks for abuse and neglect.

SPA#3 (smoking): Reduce smoking among all women of childbearing age / Decrease the percent of women who are pregnant who smoke (especially on Medicaid)

Another problem Indiana is facing is smoking among women of childbearing age (14-44 years old). Even though the rates have been decreasing since 2001, Indiana remains consistently higher than the rest of the United States. Indiana's rates peaked in 2001 at 33.6% and have since steadily decreased to 26.8% in 2007. The US percentage in 2007 was much lower at 21.2% of women smoking between the ages of 18 and 44. Smoking during pregnancy increases the risk for both a preterm delivery as well as a low birthweight baby. It has also been linked to congenital abnormalities in the infant as well as placental problems for the mother. Indiana has shown a decreasing trend in the percentage of women who smoke between 2003 and 2007, before slightly increasing. Another population that has a high smoking rate is pregnant women on Medicaid. This is alarming since 51% of pregnant women in Indiana were on Medicaid in 2007. The majority of counties (68 out of 92) have 30% or more women [on Medicaid] attesting to smoking during pregnancy in 2007. The overall percentage of women on Medicaid who smoked during pregnancy was 27 percent, compared to 17.3% for all pregnant women in Indiana.

SPA#8 (obesity): Decrease the percent of those who are obese

Prevalence of gestational diabetes (GDM) has fluctuated over the 2006-08 time period but both blacks and Hispanics have seen an increase during 2008. This is a concern since having gestational diabetes increases the risk of developing diabetes later in life. Women who are diagnosed with gestational diabetes have a 20% to 50% chance of developing diabetes in the next 5 to 10 years. Black, Hispanic, and American Indian females are at greater risk of developing gestational diabetes than white females. Global data also estimate a threefold increased risk of the mothers developing diabetes later in life and eightfold increased risk of the offspring developing diabetes or pre-diabetes by ages 19 to 27. US data estimate a 15% to 50% increased risk of a woman developing diabetes later in life, if she has a history of GDM. The primary immediate risk from uncontrolled GDM for both mother and child results from a tendency for the baby to be large for gestational age (macrosomia). This leads to increased difficulty with delivery due to the large size, and increased risk of complications to both mother and child, including physical trauma during the birth process.

RECOMMENDATIONS FOR ACTION PLAN: WOMEN OF CHILDBEARING AGE 14-44

The Action Plan below provides recommended activities and measurable outcomes for each priority area within the specified service category. These are RECOMMENDED EXAMPLES of priority measures, activities, and outcomes a program can address. Please choose the activities and correlated measurable outcomes based on your organization's selected priority measures.

Recommendations for Action Plan: Women of Childbearing Age 14-44		
Priority Areas	**Recommended Activities**	**Measurable Outcomes**
SPA #6 (birth spacing): Decrease the percent of births occurring within 18 months of previous birth	Incorporate preconception education and screening into clinical practice Implement programs such as —Every Woman, Every Time,‖ —Family Life Planning,‖ or other best practice models. Implement interconception follow up of mother with very low birthweight babies and preterm infants to address health and psychological issues of mother Implement life plan Educate on spacing importance Illustrate how preconception education and screening are incorporated into routine clinical practice	Number of providers educated Number of families, mothers, women, girls, fathers educated Number of tools disseminated Number of mothers receiving follow up surveys, care, interventions, etc. Change in attitude / behavior Change in routine clinical practices Change in practice policies
FPA #2 (preconception): Increase women with preconception counseling prior to pregnancy	Engage in preconception counseling Refer women to preconception counseling Educate providers on preconception counseling Ask women if they want to become pregnant Educate all women who receive a pregnancy test with information pertaining to preconception counseling Educate women on the importance of folic acid supplements even for women not necessarily interested in planned conception in the next 24 months. Screen women for hyperglycemia and address hyperglycemia management issues among women of childbearing age Ensure women of childbearing age are up-to-date on their immunizations, including rubella, influenza, hepatitis, etc. Educate and encourage women of childbearing age about the importance of and how to establish a healthy diet / nutrition habits / exercise regimen, including a diet low in phenylalanine. Educate women and screen for STIs to ensure all identified infections are identified, treated, and managed prior to conception	# of enrolled women who want to become pregnant who received preconception counseling compared to # of enrolled women who want to become pregnant #of women who are asked if they want to become pregnant within the FY year. #of women enrolled in the quarter #of women with a negative pregnancy test who receive preconception education # of months between pregnancies (to increase pregnancy intervals) Conduct in depth correlation analyses for any programs implemented with pre/post tests, surveys, patient satisfaction levels, provider satisfaction, etc.

	Educate women on the importance of dental health and connect/refer/screen them for periodontal disease, as direct links exist between a mother's oral health and her offspring's risk for dental carries and dental interventions can reduce the risks of prematurity and low birthweight. Implement effective intervention methodology such as the Five As (Ask, Advise, Assess, Assist, and Arrange) for behaviors such as smoking or alcohol use. Follow clinical practice guidelines for preconception care for specific maternal chronic conditions that may affect a woman's pregnancy and/or her baby (such as guidelines developed by the American Diabetics Association for women identified with diabetes; or guidelines developed by the American Association of Clinical Endocrinologists for women with hypothyroidism). Increase public awareness of the importance of preconception health behaviors with culturally competent, age appropriate, SES appropriate, educationally fitting materials—focus groups, case analysis, etc. will help inform specific messages to be delivered to consumers.	
FPA #1 (unintended pregnancies): Reduce unintended pregnancy among women of childbearing age	Health education on HIV, STD, life style behaviors, healthy habits, contraception choices, abstinence Assess all clients for contraception method problems at time of method pick-up/exam.	Proportion of unintended pregnancies due to failed contraception or failure to use contraception # of clients receiving contraceptive services who become pregnant. # of clients receiving contraceptive services #of clients assessed for contraceptive method problems during quarter #of enrolled clients during quarter # of months between pregnancies (to increase pregnancy intervals)
SPA#3 (smoking): Reduce smoking among all women of childbearing age / Decrease the percent of women who are pregnant who smoke (especially on Medicaid)	Ask clients if they smoke at time of enrollment and document smoking in chart. Monitor all clients at each visit for smoking status Educate clients at time of enrollment and provide education hazards of smoking Referral women identified as smoking at time of enrollment / refer women to the Indiana Tobacco Quitline	# of newly enrolled clients with documented smoking status each quarter # of charts with documented smoking status per visit each quarter # of unduplicated smoking clients per quarter # of women identified as smokers at time of enrollment who receive education on the hazards of smoking # of clients referred to the Indiana Tobacco Quitline. # clients who state they are smoking at time of enrollment
SPA#8: (obesity):	Document appropriate weight for age for all	Proportion of participants with a Body

Reduce overweight and obesity	clients using age appropriate ht/wt chart. Counsel all patients who are at 85th percentile with other related interventions Assess BMI at time of enrollment Provide intervention and / or treatment for all clients with a BMI greater than 29	Mass index indicating overweight or obesity who have received healthy weight counseling and/or other related interventions or treatment # of participants with a height for weight at or over the 85th percentile receiving a brief intervention of treatment # of participants with a height for weight $\geq$85th percentile #of clients with ht/wt documented #of enrolled clients during quarter # of participants with a height for weigh at or over the 85th percentile receiving a brief intervention of treatment #of clients with BMI documented # of clients with BMI over 29 who receive brief intervention and/or treatment during the quarter # of clients with BMI over 29 during the quarter

Description of Family Planning Priorities to be Addressed by Family Planning Administrator

ISDH's MCH Division will be awarding one large grant to an organization capable of serving as the State's Family Planning Administrator. As such, this organization will be the recipient and manager for all funds through the Indiana Family Planning Partnership (administered by MCH) to provide services to all women most in need throughout the state and especially those in counties identified to be most in need of services. The Family Planning Administrator will encourage cost-effective use of medical and community resources and promote the overall wellbeing of the individual and family, emphasize confidentiality and provide services at no cost to the clients whose income is less than 100% of the federal poverty guidelines and on a sliding scale for clients with income up to 250% of the federal poverty guideline.

There is potential for significant additional dollars through the Indiana Family Planning Partnership. However, the Family Planning Administrator will only be awarded funding from MCH through this grant opportunity.

The Family Planning Administrator will be required to: (1) Award Sub-Grants; (2) Serve as liaison between ISDH and Sub-Grantees for Family Planning activities; (3) Provide technical assistance to Sub-Grantees; (4) Monitor Sub-Grantees; (5) Report on status of Sub-Grantees; and (6) Provide fiscal oversight. Detailed information regarding each priority area, including required activities and measurable outcomes, are listed in the table below.

Description of Family Planning Priorities to be Addressed by Sub-Grantees of the Family Planning Administrator

FPA #1 (unintended pregnancies): Reduce unintended pregnancy among women of childbearing age

The CDC states that –an unintended pregnancy is a pregnancy that is either mistimed or unwanted at the time of conception. Unintended pregnancy is associated with an increased risk of morbidity for women, and with health behaviors during pregnancy that are associated with adverse effects.‖ Nationally, almost half of all pregnancies are unintended. Several safe and highly effective methods of contraception (birth control) are available to prevent unintended pregnancy. However, organizations must take a proactive role in helping women to increase effective contraceptive use and adherence.

According to the Guttmacher Institute, nationally, –the rate of unintended pregnancy in 2001 was substantially above average among women aged 18–24, unmarried (particularly cohabiting) women, low-income women, women who had not

completed high school and minority women. Between 1994 and 2001, the rate of unintended pregnancy declined among adolescents, college graduates and the wealthiest women, but increased among poor and less educated women. The abortion rate and the proportion of unintended pregnancies ending in abortion among all women declined, while the unintended birth rate increased. Forty-eight percent of unintended conceptions in 2001 occurred during a month when contraceptives were used, compared with 51% in 1994.

Unintended pregnancies are associated with several negative consequences, including: (1) women are less likely to obtain adequate prenatal care in the first trimester; (2) women are more likely to continue to use alcohol and tobacco during pregnancy; (3) women who are already in a relationship involving physical abuse may be at greater risk with their partners; (4) women are more likely to have or seek an abortion; and (5) infants and children born to women with unplanned pregnancies are at greater risks for abuse and neglect.

FPA #2 (preconception /interconception health): Increase number of women receiving preconception counseling prior to pregnancy

According to the CDC, —by age 25 years, approximately half of all women in the United States have experienced at least one birth, and approximately 85% of all women in the United States have given birth by age 44 years.‖ Although 84% of women of childbearing age had a health care visit within the last year, as the CDC reports, only one in six OB/GYNs or family physicians provided preconception care to the majority of women for whom they provided prenatal care. These statistics indicate that while the majority of women can expect to become a mother, very few can expect to receive any preconception or interconception counseling.

The CDC notes that –improving preconception health can result in improved reproductive health outcomes, with potential for reducing societal costs as well. Preconception care aims to promote the health of women of reproductive age before conception and thereby improve pregnancy-related outcomes.‖ The recommendations for preconception care from the CDC include:

1) Individual responsibility across the lifespan
2) Consumer awareness
3) Preventive visits
4) Interventions for identified risks
5) Interconception care
6) Pre-pregnancy checkup
7) Health insurance coverage for women with low income
8) Public health programs and strategies
9) Research

10) Monitoring improvements.

The primary goal of preconception and interconception care is to promote, screen, and provide services and programs for women of childbearing age to reduce risks that may influence forthcoming pregnancies and deliveries. Providing some form of interconception health to every single woman seen for primary, secondary, or even tertiary care can aid physicians in identifying and treating conditions that can lead to healthier mothers and babies.

While multiple components are important for preconception and interconception health, please note the CDC reports that –the best evidence for the effectiveness of these specific components of preconception care has been documented when the focus of delivery was on a single risk behavior and accompanying intervention, rather than delivery of multiple interventions.‖

FPA# 3: Increase the percent of clients who receive a pelvic examination within the past 12 months

Pelvic exams are done in order to assess one's gynecologic health or to diagnose a medical condition. A pelvic exam often is part of a routine physical exam for women to find possible signs of a variety of disorders, such as ovarian cysts, sexually transmitted infections, uterine fibroids or early-stage cancer. A doctor can recommend how frequently a woman needs to be examined, but many women have a pelvic exam once a year. A doctor may suggest a pelvic exam for gynecologic symptoms, such as pelvic pain, unusual vaginal bleeding, skin changes, abnormal vaginal discharge or urinary problems. A pelvic exam can help a doctor diagnose possible causes of these symptoms and determine if other diagnostic testing or treatment is needed (source: Mayo Clinic).

SPA#8 (obesity): Reduce overweight and obesity

The overall goal outlined in Healthy People 2020 is to decrease the proportion of overweight 9th through 12th graders from 11 to 5 percent. The 2009 Youth Risk Behavior Survey YRBS (http://www.in.gov/isdh/20627.htm), for grades nine through twelve, looked at key areas which contribute to weight and nutrition. One key area of concern is overweight and obese children. In youth, obesity is linked to high blood pressure, type 2 diabetes, and high cholesterol. Obesity can also lead to coronary heart disease later in life. In the 2009 YRBS report for Indiana, 12.8% of youth reported they are obese (at or above the 95th percentile for their age, sex and BMI), which is down from 15% in 2005. The data show that 15.9% of youth are overweight (between 85th and 94th percentile), which is a full percent and a half higher than in 2005, (14.3%).

SPA#3 (smoking): Decrease the percent of women who are pregnant who smoke (particular attention should be made to pregnant women on Medicaid)

Although smoking rates have been decreasing since 2001, Indiana remains consistently higher than the rest of the United States. Indiana's rates peaked in 2001 at 33.6% and have since steadily decreased to 26.8% in 2007. The US percentage in 2007 was much lower at 21.2% of women smoking between the ages of 18 and 44. Figure 4, from the March of Dimes, compares the percentage of women in Indiana aged 18 to 44 who smoke, with the national rate. Smoking during pregnancy increases the risk for both a preterm delivery as well as a low birthweight baby. It has also been linked to congenital abnormalities in the infant as well as placental problems for the mother. Indiana has shown a decreasing trend in the percentage of women who smoke between 2003 and 2007, before slightly increasing. A population that has a high smoking rate is pregnant women on Medicaid. This is alarming since 51% of pregnant women in Indiana were on Medicaid in 2007. The majority of counties (68 out of 92) have 30% or more women on Medicaid attesting to smoking during pregnancy in 2007. The overall percentage of women on Medicaid who smoked during pregnancy was 27 percent, compared to 17.3% for all pregnant women in Indiana.

NPA#8 (births to teens): Decrease the rate of births (per 100,000) for teenagers ages 15-17

An increase in sexual activity among adolescents and young people in Indiana and the United States has lead to an alarming number of teen pregnancies. Although the teen birth rate in both Indiana and the United States has declined significantly between the early 1990's and today, Hoosier adolescents are still at great risk for becoming pregnant or causing a pregnancy. According to the National Campaign to Prevent Teen and Unplanned Pregnancy, had the teen birth rate in Indiana not declined 26%between 1991 and 2002, there would have been nearly 19,000 additional children born to teen mothers during those years. In 2002, there would have been nearly 5,800 more children in poverty and nearly 6,700 additional children living with a single mother. The 2009 Youth Risk Behavior Survey (YRBS) data for Indiana reveal that 49.2% of high school students have ever had sexual intercourse; 36.7% have had sexual intercourse with one or more people during the past three months; and among students who have had sexual intercourse during the past three months, 58% used a condom during last sexual intercourse and 23.2% used birth control pills to prevent pregnancy.

SPA#9 (STI): Decrease percent of STIs (specifically gonorrhea and Chlamydia) *among women of childbearing ages & high school students*

Every year one out of four sexually active teens becomes infected with an STD in the US. In 2009, one out of every three Chlamydia cases in Indiana was someone under the age of 19. One out of four cases of Gonorrhea was someone under 19. In 2009, females had 75% of the Chlamydia cases and about 58% of the Gonorrhea cases. Black non-Hispanics were more likely to have Chlamydia and Gonorrhea in 2009 than white non-Hispanics. The emerging adult population of ages 20-24 had the most cases of Chlamydia and Gonorrhea in Indiana in 2009. The younger an individual

initiates sexual intercourse, the more likely they are to have more lifetime sexual partners, the higher the risk of pregnancy, and the lower the chances of using contraception. In Indiana, the percentage of high school students who reported ever having sex did not significantly change between 2003 and 2009 (48.8% to 49.2%). The percentage of students who reported using a condom during their last sexual intercourse also did not change significantly between 2003 and 2009 (55.4% to 58.0%). The 2009 YRBS data indicate that 4.5% of the students interviewed reported having their first sexual intercourse before the age of 13. In addition, 21.0% reported using drugs or alcohol before their last sexual intercourse. About 1 in 4 students reported using birth control pills before their last sexual intercourse. Approximately 14% of students reported having four or more sexual partners in their lifetime. In Indiana in 2006, approximately 11% of the births to residents were by youth age 19 and under. This percent is slightly down from 2005. This number has been decreasing since 1996.

SPA#6 (birth spacing): Decrease the percent of births that occur within 18 months of previous birth to the same birth mother

Short interpregnancy interval is defined as less than 12 completed months between the last live birth and conception. According to a John Hopkins' report and the International Journal of Gynecology & Obstetrics, babies born after a short interpregnancy interval are at greater risk of low birthweight. Since the early 1990_s, the percentage of Indiana births following a short interpregnancy interval of less than 12 months declined by 14 percent, from 21.1 to 18.3 percent. In the 2002-2005 period, 9.2%of non-Hispanic black multiparous mothers had an interpregnancy interval of less than 6 months compared to 5.5 and 6.9%among their non-Hispanic white and Hispanic counterparts, respectively. According to the Pregnancy Nutrition Surveillance System (PNSS) which, in Indiana, is collected during prenatal WIC visits, Indiana has had higher rates of short interpregnancy interval compared to the US over the 3 years (2004-2006). Considering the adverse effect of short interpregnancy intervals of up to 12 months on birth outcomes, efforts of public health agencies to improve birth spacing should continue beyond 6 months postpartum, especially in those high risk populations such as non-Hispanic blacks, Hispanics, the young, unmarried and less educated mothers.

RECOMMENDATIONS FOR ACTION PLAN: FAMILY PLANNING

The Action Plan below provides REQUIRED Family Planning Administrator (FPAP) priority areas for the Family Planning Administrator and its corresponding activities and measurable outcomes

REQUIRED Activities for Family Planning ADMINISTRATOR		
Priority Areas	**Required Activities**	**Measurable Outcomes**
FPAP#1: Award Sub-Grants	Develop and release Request for Proposals (RFP) Identify Sub-Awardees Negotiate activities, outcomes to be measured, etc. Sub-award grant contracts to identified sub-awardees	RFP completed, and submitted for review and approval by ISDH before release Number of applicants/ respondents to RFP Identification of clinics to be funded for family planning services
FPAP#2: Serve as liaison between ISDH and Sub-Grantees for Family Planning activities	Work closely with ISDH's MCH State Adolescent Health Coordinator Attend meetings as required by ISDH Relay information from ISDH to Sub-Grantees Provide referrals from Sub-Grantees to ISDH's Home Visiting Program	Updates and communication via phone and email with State Adolescent Health Coordinator Meetings and/or trainings attended related to family planning Number of local, state and national meetings and conferences attended as a representative of family planning for Indiana Updated or new information provided to State Adolescent Health Coordinator
FPAP#3: Provide technical assistance to Sub-Grantees	Provide up-to-date information to Sub-Grantees re: stats, current practices, best practices, evidence-based models, promising practices Provide face-to-face and electronic technical assistance to Sub-Grantees Assist Sub-Grantees in developing sound activities Assist Sub-Grantees through difficulties in hiring, recruiting, implementation, data collection / analysis / reporting	Number of contacts/ communications with sub-grantees Number of online trainings/webinars provided to sub-grantees Number of site visits to clinics conducted
FPAP#4: Monitor and Report on status of Sub-Grantees	Assist Sub-Grantees in developing sound measurable outcomes Assist Sub-Grantees in fiscal responsibility Collect, analyze, and report status of each Sub-Grantee's progress to ISDH Assess Sub-Grantees for incompletion of stated outcomes and activities Report outstanding issues and discrepancies of Sub-Grantees to ISDH	Conduct site visits to clinics Ensure compliance with medical standards and guidelines Conduct annual clinic reviews with chart audits Ensure monthly invoicing from sub-awardees Ensure completion and submission of quarterly and annual reports on all performance measures and

		activities
FPAP#5: Fiscal oversight	Assist Sub-Grantees invoicing for services Assist Sub-Grantees in financial activities, including recording program related expenditure and revenue	Number of conducted site visits Number of conducted financial audits Monthly invoicing from sub-awardees completed.

The Action Plan below provides RECOMMENDED priority areas and its corresponding activities and measurable outcomes for SUB-GRANTEES of the Family Planning Administrator.

RECOMMENDED Activities for Family Planning SUB-GRANTEES (to be awarded by Family Planning ADMINISTRATOR)		
Priority Areas	**Recommended Activities**	**Measurable Outcomes**
FPA #1 (unintended pregnancies): Reduce unintended pregnancy among women of childbearing age	Health education on HIV, STD, life style behaviors, healthy habits, contraception choices, abstinence Assess all clients for contraception method problems at time of method pick-up/exam.	Proportion of unintended pregnancies due to failed contraception or failure to use contraception # of clients receiving contraceptive services who become pregnant. # of clients receiving contraceptive services #of clients assessed for contraceptive method problems during quarter #of enrolled clients during quarter # of months between pregnancies (to increase pregnancy intervals)

FPA #2 (preconception): Increase women with preconception counseling prior to pregnancy	Engage in preconception counseling Refer women to preconception counseling Educate providers on preconception counseling Ask women if they want to become pregnant Educate all women who receive a pregnancy test with information pertaining to preconception counseling Educate women on the importance of folic acid supplements even for women not necessarily interested in planned conception in the next 24 months. Screen women for hyperglycemia and address hyperglycemia management issues among women of childbearing age Ensure women of childbearing age are up-to-date on their immunizations, including rubella, influenza, hepatitis, etc. Educate and encourage women of childbearing age about the importance of and how to establish a healthy diet / nutrition habits / exercise regimen,	# of enrolled women who want to become pregnant who received preconception counseling compared to # of enrolled women who want to become pregnant #of women who are asked if they want to become pregnant within the FY year. #of women enrolled in the quarter #of women with a negative pregnancy test who receive preconception education # of months between pregnancies (to increase pregnancy intervals) Conduct in depth correlation analyses for any programs implemented with pre/post tests, surveys, patient satisfaction levels, provider satisfaction, etc.

	including a diet low in phenylalanine. Educate women and screen for STIs to ensure all identified infections are identified, treated, and managed prior to conception Educate women on the importance of dental health and connect/refer/screen them for periodontal disease, as direct links exist between a mother's oral health and her offspring's risk for dental carries and dental interventions can reduce the risks of prematurity and low birthweight. Implement effective intervention methodology such as the Five As (Ask, Advise, Assess, Assist, and Arrange) for behaviors such as smoking, alcohol use or drug use. Follow clinical practice guidelines for preconception care for specific maternal chronic conditions that may affect a woman's pregnancy and/or her baby (such as guidelines developed by the American Diabetics Association for women identified with diabetes; or guidelines developed by the American Association of Clinical Endocrinologists for women with hypothyroidism). Increase public awareness of the importance of preconception health behaviors with culturally competent, age appropriate, SES appropriate, educationally fitting materials—focus groups, case analysis, etc. will help inform specific messages to be delivered to consumers.	
FPA#3 (exams): Increase the percent of clients who receive a pelvic examination within the past 12 months	Ask client when she had her last pelvic exam at time of enrollment and document in chart Monitor clients at each visit for status of a pelvic exam within the past year Educate clients at time of enrollment about the benefits of a pelvic exam Provide a pelvic exam to women of childbearing age	Percent of clients who have had a pelvic exam within the 12 months
SPA#8: (obesity): Reduce overweight and obesity	Document appropriate weight for age for all clients using age appropriate ht/wt chart. Assess BMI at time of enrollment Counsel all patients who are at 85th percentile with other related interventions Provide intervention and / or treatment	Proportion of participants with a Body Mass index indicating overweight or obesity who have received healthy weight counseling and/or other related interventions or treatment # of participants with a height for weight at or over the 85th percentile receiving a brief intervention of

	for all clients with a BMI greater than 29	treatment # of participants with a height for weig ≥85th percentile #of clients with ht/wt documented #of enrolled clients during quarter # of participants with a height for weigh at or over the 85th percentile receiving a brief intervention of treatment #of clients with BMI documented # of clients with BMI over 29 who receive brief intervention and/or treatment during the quarter # of clients with BMI over 29 during the quarter
SPA#3 (smoking): Decrease the percent of women who smoke (especially on Medicaid)	Ask clients if they smoke at time of enrollment and document smoking in chart Monitor all clients at each visit for smoking status Educate clients at time of enrollment and provide education hazards of smoking Refer women identified as smoking at time of enrollment / refer women to the Indiana Tobacco Quitline	# of newly enrolled clients with documented smoking status each quarter # of charts with documented smoking status per visit each quarter # of unduplicated smoking clients per quarter # of women identified as smokers at time of enrollment who receive education on the hazards of smoking # of clients referred to the Indiana Tobacco Quitline. # clients who state they are smoking at time of enrollment
NPA#8 (births to teens): Decrease the rate of births (per 100,000) for teenagers ages 15-17	Collaborate with schools to ensure the implementation of evidence based sexual health programs Involve the community in discussions of what it wants and need from adolescent sexual health programs Create and/or market venue (website, social media page, hotline) for adolescents to easily access accurate sexual health information Health education on HIV, STD, life style behaviors, healthy habits, contraception choices, abstinence Assess all clients for contraception method problems at time of method pick-up/exam.	Number/percentage of students who have ever had sexual intercourse Number/percentage of students using condoms (or contraceptive use) during last sexual intercourse Change in students' knowledge around sexual health following program Number of teen births in a school following the implementation of evidence based program Number of births (per 100,000) for teenagers ages 15-17 Number accessing created/marketed venue (website, social media page, hotline)

SPA#9 (STIs): Decrease percent of STIs (specifically gonorrhea and Chlamydia) among women of childbearing ages & high school students	Collaborate with schools to ensure the implementation of evidence based sexual health programs Involve the community in discussions of what it wants and need from adolescent sexual health programs Create and/or market venue (website, social media page, hotline) for adolescents to easily access accurate sexual health information Health education on HIV, STD, life style behaviors, healthy habits, contraception choices, abstinence Assess all clients for contraception method problems at time of method pick-up/exam Provide testing for STIs, specifically gonorrhea and Chlamydia among clients	Number/percentage of students who have ever been taught about AIDS or HIV infection in schools Number of clients with a positive test for gonorrhea or Chlamydia who receive treatment Number/percentage of students who have ever had sexual intercourse Number/percentage of students using condoms (or contraceptive use) during last sexual intercourse
SPA #6 (birth spacing): Decrease the percent of births occurring within 18 months of previous birth	Incorporate preconception education and screening into clinical practice Implement programs such as ―Every Woman, Every Time,‖ ―Family Life Planning,‖ or other best practice models. Implement interconception follow up of mother with very low birthweight babies and preterm infants to address health and psychological issues of mother Implement life plan Educate on spacing importance Illustrate how preconception education and screening are incorporated into routine clinical practice	Number of providers educated Number of families, mothers, women, girls, fathers educated Number of tools disseminated Number of mothers receiving follow up surveys, care, interventions, etc. Change in attitude / behavior Change in routine clinical practices Change in practice policies

DESCRIPTION OF CHILDREN & YOUTH WITH SPECIAL HEALTH CARE NEEDS

Children and youth with special health care needs (CYSHCN) are children and youth who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who require health and related services of a type or amount beyond that required by children generally (MCHB). This group of children includes those with or at increased risk for chronic physical illnesses and disabilities, developmental disabilities and emotional and behavioral disorders.

The 2009/2010 National Survey of Children with Special Health Care Needs (NS-CSHCN) found that over 11 million children or 15.1% of all children in the United States had special needs. In Indiana, the percentage is much higher, with 17.0% of children having special health care needs. This equates to approximately 270,000 children in Indiana. Indiana has the third highest prevalence of children with special needs in Region V as shown in the following table:

Percentage of Children with Special Health Care Needs
Indiana, Region V, and the United States: 2009/2010

State	Percent Children
Indiana	17.0 (15.7-18.2)*
Illinois	14.3 (13.2-15.5)*
Michigan	18.4 (16.7-20.1)*
Minnesota	14.3 (13.2-15.3)*
Ohio	17.8 (16.6-19.1)*
Wisconsin	15.5 (14.2-16.8)*
Region V	16.3 (15.7-16.9)*
United States	15.1 (14.8-15.3)*

*95% confidence interval

Source: Child and Adolescent Health Measurement Initiative. *2009/2010 National Survey of Children with Special Health Care Needs*, Data Resource Center for Child and Adolescent Health website. Retrieved [02/20/13] from www.childhealthdata.org

In 2006, there were 89,404 births in Indiana, and many of these infants have or are at risk for special health care needs. Of the total births in Indiana during 2006, 8.2% were low birthweight infants (less than 2500 grams) with 10.3% being premature. Approximately 23% of Indiana's total births were to women with less than twelve years of education and over 41.2% of babies are born to unmarried mothers. A majority (52%) of Indiana children live in female-headed households. Such socio-demographic factors place children at higher risk for developmental delays and unmet needs. Looking at Children and Youth with Special Health care Needs (CYSHCN) by Poverty Level, the highest percentage of Indiana Children with Special Health care Needs (CSHCN) is seen at the 0%-99% Federal Poverty Level (FPL). Differences are observed in Indiana and national CYSHCN prevalence rates by poverty level. (See Table below.)

Percentage Prevalence of Children with Special Health Care Needs by Federal Poverty Level (FPL): 2009/2010

Percent Federal Poverty Level	Indiana (%)	National (%)
0-99%	19.2	16.0
100-199%	15.8	15.4
200-399%	16.7	14.5
400% or more	16.5	14.7

Source: *NS-CSHCN Chartbook 2009/2010*

Both males (18.7%) and females (14.5%) in Indiana have a higher prevalence of special health care needs than their peers in the US (16.1% and 11.6%). Indiana also has higher percentages in Non-Hispanic white (17.2 to 15.5) and Hispanic (8.9 to 8.3) against the US, but is lower in Non-Hispanic black (14.5 to 15.0). Of these children with special health needs, approximately one-third of them do not have adequate health insurance (38.2-38). These conditions cause approximately one out of every four children to have family members reduce hours or quit working (24.3-23.8).

Children with special health care needs and their families need coordinated systems of care in their communities that promote effective, family-centered, integrated system of services and supports. The MCHB has identified Six Core Components for successful systems of care for CYSHCN and their families. Achieving each of the Six Core Outcomes for all children and youth with special health care needs and their families will require addressing cultural and linguistic competence in creating systems of services and supports. The six areas are discussed below.

Core Outcomes for Children with Special Health Care Needs Indiana and United States: 2009/2010

Outcome Criteria	Indiana	United States
CSHCN whose families are partners in shared decision-making, at all levels, for child's optimal health	72.6	70.3
CSHCN who received coordinated, ongoing, comprehensive care with a medical home	48.5	43.0
CSHCN whose families have adequate private and/or public insurance to pay for the services they need	58.6	60.6
CSHCN who are screened early and continuously for special health care needs	79.1	78.6
CSHCN can easily access community-based services	65.9	65.1
Youth with special health care needs who receive the services necessary to make appropriate transitions to adult health care, work and independence	43.7	40.0

Source: Child and Adolescent Health Measurement Initiative. *2009/2010 National Survey of Children with Special Health Care Needs*, Data Resource Center for Child and Adolescent Health website. Retrieved [02/20/13] from www.childhealthdata.org

Description of Priority Areas

NPA#1(family involvement): Increase percent of children with special health care needs age 0-21 years whose family's partner in decision making at all levels and are satisfied with the services they receive

Outcome - Family-centered care is based on the recognition that children live within the context of families—which may include biological, foster, and adoptive parents, step-parents, grandparents, other family caregivers, and siblings. Family-centered care is a process to ensure that the organization and delivery of services, including health care services, meet the emotional, social, and developmental needs of children; and that the strengths and priorities of their families are integrated into all aspects of the service system. (NS-CSHCN Chartbook 2005/2006).

Nationally, 70.3% of families believe that they are partners in decision making at all levels and are satisfied with the services they receive.Families in Indiana rate their satisfaction in this area at 72.6%, leaving a significant gap of 27.4% of families in Indiana who do not feel as though they have an adequate level of partnership or satisfaction with services available to their CYSHCN (NS-CSHCN 2009/2010). With an estimated 270,000 CYSHCN in Indiana, this means approximately 74,000 families in Indiana are not satisfied with the services they receive for their children or their level of partnership with those either providing services or making decisions regarding the services.

NPA#2 (medical home): Increase percent of children with special health care needs age 0-21 who receive coordinated, ongoing, comprehensive care within a medical home

Outcome - A medical home means a source of ongoing, comprehensive, coordinated, family-centered care in the child's community. Child health care professionals and families agree that medical homes provide important and unique benefits to children and youth with special health care needs. The medical home can and should provide preventive services, immunizations, growth and developmental assessments, appropriate screening, health care supervision, and patient and family counseling about health and psychosocial issues. The medical home also can and should ensure that children have continuity of care from visit to visit, from infancy through transition into adulthood. In addition, it must be supported to provide care coordination services so that each family and all the professionals serving them work together, as an organized team, to implement a specific care plan and to address issues as they arise. (NS-CSHCN Chartbook 2005/2006).

According to the NS-CSHCN 2009/2010, , 43.0% of CYSHCN receive coordinated, ongoing, comprehensive care within a medical home on the national level. Indiana's CYSHCN have a higher percentage of those receiving care within a medical home at 48.5% There is still a significant gap of more 51.5% CYSHCN without a medical home. The CSHCS Program and Indiana's Medicaid program assure that every enrolled child has a primary care physician; however, this may not indicate that the child has a Medical Home. Coordination with specialty care is often times problematic for some children. (IN CISS Grant application, March 2009).

*NPA#3(insurance): Increase percent of children with special health care needs age 0-*21 *whose families have adequate private and/or public insurance to pay for the services they need*

Health insurance coverage plays a critical role in ensuring access to family-centered care for CSHCN. For children, gaps in health care financing may mean that health care is delayed or that services are not delivered. Uninsured and underinsured children are less likely to receive care in a medical home that addresses their comprehensive needs. The availability of private or public insurance is strongly associated with the ability to obtain community-based services such as medical care, dental care, mental health services, medical equipment, supplies and prescriptions. (NS-CSHCN Chartbook 2005/2006). Nationally, 60.6%of families believe that they have adequate private and/or public insurance to pay for the services they need for their CYSHCN. Approximately, 58.6% of Indiana families believe that they have adequate health care coverage. (NS-CSHCN 2009/2010).

NPA#4 (early screening): Increase percent of children age 0-21who are screened early and continuously for special health care needs.

In public health, screening often refers to a population-based intervention to detect a particular condition or disease. However, as used in the context of this goal, screening is much more comprehensive and includes ongoing monitoring and assessment of children and youth to promote health and well-being through family-centered care practices. Seen this way, screening has two major goals. First, it is critical to identify, as early as possible, children in the general population who have special health care needs so that they and their families can receive appropriate services to reduce long term consequences and complications. Some needs may be identified in infancy, or during the perinatal period, while others may emerge later in childhood and adolescence. Second, and equally important, children and youth with special health care needs require ongoing assessments to identify newly emerging issues including developmental/behavioral issues, oral health, and psychosocial issues, and to prevent secondary conditions that may interfere with development and well-

being. Ongoing assessment should also focus on identifying the unique strengths of each child and family. (NS-CSHCN Chartbook 2005/2006). According to the NS-CSHCN 2009/2010 report of Indiana parents of CYSHCN, 79.1% report that they received early and continuous screening compared to 78.6% nationally.

NPA#5 (services): Increase percent of children with special health care needs age 0-21 whose families report the community-based service system are organized so they can use them easily

A community-based system of services is an infrastructure that operates across service sectors. It facilitates the integration of services in several dimensions—including organization, delivery, and financing. The development of community-based systems of services is a response to the complexity and fragmentation of services for children with special health care needs and their families. Multiple service programs—each with its own funding streams, eligibility requirements, policies, procedures, and service sites—serve CSHCN. It is clear that communities and their resources affect the way families of children with special health needs find and use services. Therefore, the health of communities themselves can have a positive effect on the growth and development of CSHCN. (NS-CSHCN Chartbook 2005/2006). According to the NS-CSHCN 2009/2010 report of Indiana parents of CYSHCN, 65.9% agree that these services are organized for their use compared to 65.1%nationally

NPA#6 (transition services): Increase percent of youth with special health care needs who received the services necessary to make transition to all aspects of adult life, including adult health care, work, and independence

While rapid advances in medical science have enabled nearly all children born with special needs to reach adulthood, youth with special health care needs are much less likely than their non-disabled peers to finish high school, pursue post-secondary education, get jobs, or live independently. Few coordinated services have been available to assist them in their transitions from school to work, home to independent living, and child and family-focused care to adult-oriented care. Transition planning must begin early in order to move children and families along in a developmental fashion. One of the greatest challenges in planning is how to make a successful transition from the pediatric to adult health care system for youth with special health care needs. Health care professionals, on both the pediatric and adult sides, may lack the training, support, and opportunities they need to promote the development of youth with special health care needs as partners in health care decision-making and policy formulation. Some adult health care providers may not be prepared to treat patients with complex medical conditions that begin in childhood. The challenge remains to improve the system that serves youth with special health care needs while simultaneously preparing

youth and their families with the knowledge and skills necessary to promote self-determination, wellness, and successful navigation of the adult service system. (NS-CSHCN Chartbook 2005/2006). According to the NS-CSHCN 2009/2010 report of Indiana parents of CYSHCN, 43.7% believe that they receive the services necessary to make transition to adult life compared to 43.7% nationally. There is still an overwhelming majority at close to 60% who do not.

Cultural Competence

The make-up of the American population is changing as a result of immigration patterns and significant increases among racially, ethnically, culturally and linguistically diverse populations already residing in the United States. Health care organizations and programs, and federal, state and local governments must implement systemic change in order to meet the health needs of this diverse population. (National Center for Cultural competence, Georgetown University Center for Child and Human Development, March 2013).

Indiana has experienced rapid growth in its Latino population. According to 2010 U.S. Census data, Indiana experienced an 82% increase in its Latino population from 2000-2010. Latinos represented 214,536 residents in 2000 compared to 389,707 in 2010, now comprising 6% of the state. This number has almost quadrupled since 1990 when the Latino population was 98,788 and represented 1.8% of the state. As previously mentioned, the 2009-2010 NS-CSHCN shows Indiana's percentage of CYSHCN is 17.0%, which equates to approximately 270,000 children. This approximation has remained consistent with the 2005-2006 NS-CSHCN, allowing us to estimate that Latinos represent 9% of Indiana's CYSHCN population. When examining the six core outcomes in the 2009-2010 NS-CSHCN, Indiana's Latino CYSHCN are second for unachieved outcomes (just below African-Americans) for NPA 1-5 and the highest for NPA 6. (IN Ease of Use Initiative Application, March 2012).

Along with rapid exponential growth comes an increased barrier to care from lack of insurance, interpreters, educational materials and forms that are translated into Spanish, and an insufficient capacity of state providers to assist Latino families in need of health and community-based resources. Indiana also has the largest Burmese population outside of Burma than anywhere else in the world. While there are services in placed to help this population, they may not be adequate to ensure the Burmese have access to culturally appropriate health care services. (Maternal and Child Health Services Title V Block Grant, State Narrative for Indiana, July 2011). Navigating the current fragmented and complex systems of care can be very challenging for families of CYSHCN and even more challenging for Latino and Burmese families facing the aforementioned barriers. This holds true for all racially, ethnically, culturally, and linguistically diverse populations in Indiana. We are committed to the continual use of the MCHB's framework to address gaps for CYSHCN statewide, especially to prevent minority populations from falling behind. (IN Ease of Use Initiative Application, March 2012).

RECOMMENDATIONS FOR ACTION PLAN: CHILDREN WITH SPECIAL HEALTH CARE NEEDS

The Action Plan below provides recommended activities and measurable outcomes for each priority area within the specified service category. These are RECOMMENDED EXAMPLES of priority measures, activities, and outcomes a program can address. Please choose the activities and correlated measurable outcomes based on your organization's selected priority measures.

Recommendations for Action Plan: Children with Special Health care Needs		
Priority Areas	**Recommended Activities**	**Measurable Outcomes**
NPA#1 (family involvement): Increase percent of children with special health care needs age 0-21 years whose family's partner in decision making at all levels and are satisfied with the services they receive.	Develop materials and resources for families, family leaders, and professionals about such topics as developing parent and youth leadership, building partnerships, cultural diversity, etc. Partner with organizations and agencies to promote, solicit, and facilitate opportunities for family / professional partnerships Promote specific activities to develop youth leadership Provide tools and guidance to family leaders in building an evidence base for family-centered care and by working with them to compile such information into a state perspective Utilize resources from National Center for Family/Professional Partnerships, Family Voices, and National Center for Cultural Competence (NCCC)	Change in leadership capacity and promote family-centered care and communities of learners. Change in knowledge about and opportunities for family/youth/professional partnerships in health care policies and practices Change in understanding and measurement of family-centered, culturally competent care, family/professional partnerships and other outcomes such as family satisfaction

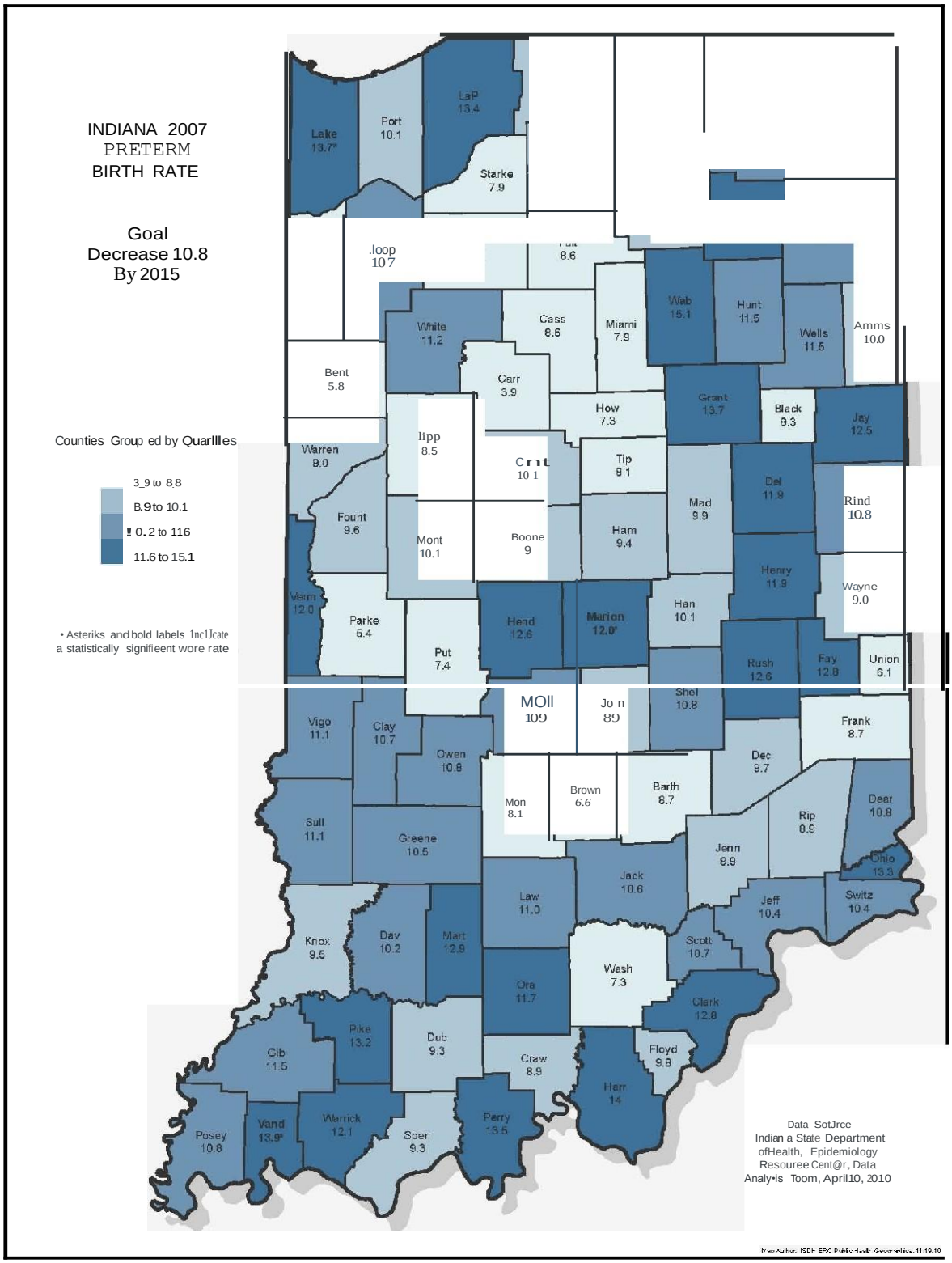
NPA#2 (medical home): Increase percent of children with special health care needs age 0-21 who receive coordinated, ongoing, comprehensive care within a medical home.	Promote Medical Home for CYSHCN and their families Provide/promote coordinated health care Prepare written care plans with the families input and share with all health care providers serving the CYSHCN and their family Collaborate with all parties involved in the care of the CYSHCN and their family to solve problems; this may include agencies, non-profits that provide services and help families in need, and schools Utilize IN Medical Home Learning Collaborative brochures for children and young adults Utilize resources from: The National Center for Medical Home's implementation plan.	Change in families' knowledge about Medical Homes Change in percent of CYSHCN and their families who say they have a Medical Home Number of primary care physician linkages made. Number of Medical Home brochures disseminated

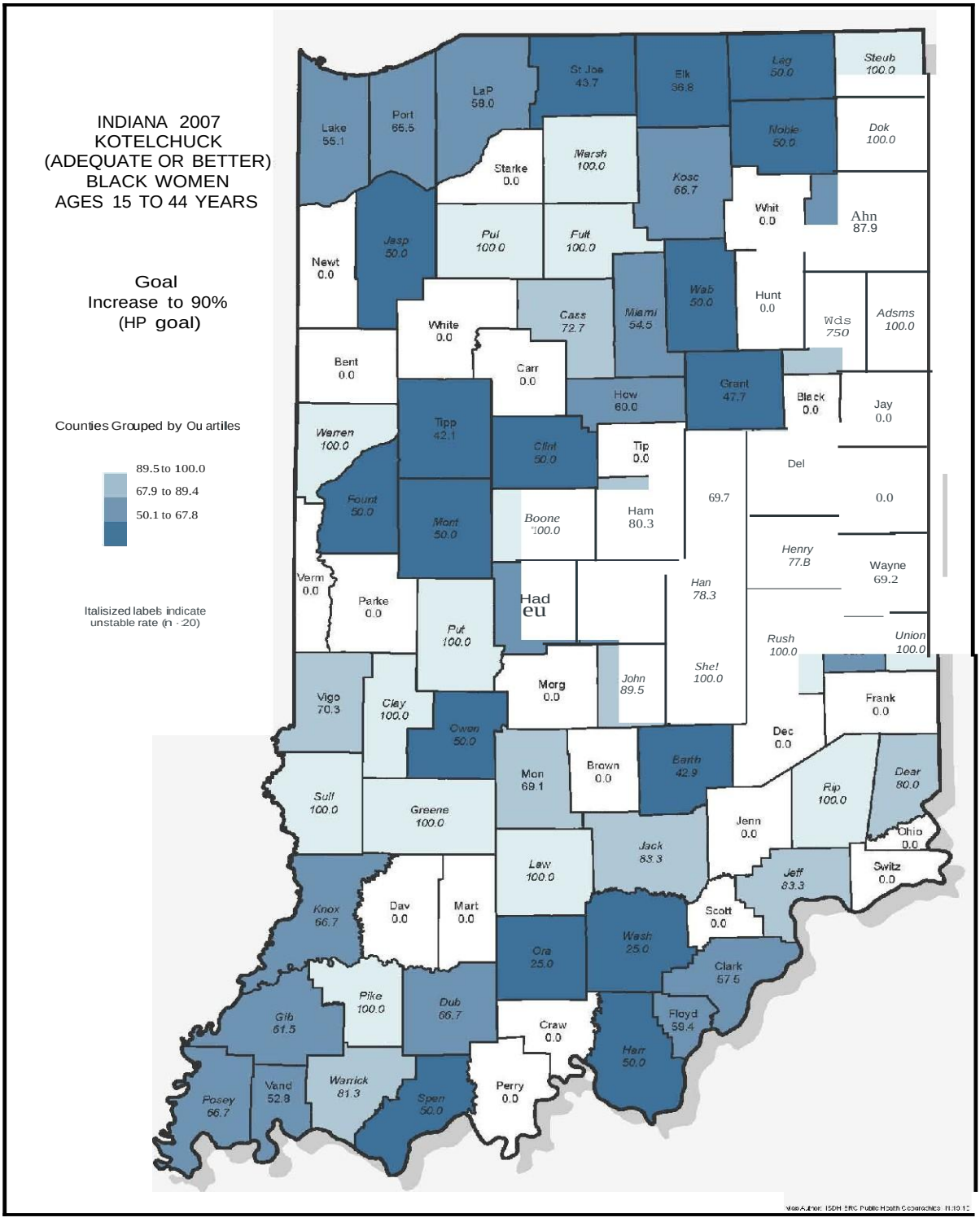
NPA#3 (insurance): Increase percent of children with special health care needs age 0-21 whose families have adequate private and/or public insurance to pay for the services they need.	Counsel families on programs that will meet their needs. Use the Sunny Start Financial Fact Sheets as resources with the CYSHCN and their families. Refer CYSHCN and their families to Indiana's family-to-family and parent-to-parent organizations Create strong public awareness initiatives to recruit eligible families for Medicaid/SCHIP, especially diverse families Training for providers to support families in obtaining insurance coverage- insurance —navigators‖ Community-based/school based health centers to support uninsured/underinsured Utilize resources from The Catalyst Center	Number of families provided with application assistance and or referrals to programs that met their needs Number of strong public awareness initiatives to recruit eligible families for Medicaid/SCHIP, esp. diverse families Number of primary care physician linkages made. Number of Medical Home brochures disseminated.
NPA#4 (early screening): Increase percent of children age 0-21 who are screened early and continuously for special health care needs.	Dissemination of *Act Early. Learn the Signs. Campaign*, "Roadmap to Services", Sunny Start, and other statewide materials. Ongoing monitoring and assessment of children and youth to promote health and well-being through family-centered care practices. Conduct follow-up for children and youth identified with a special health care need. Address the multiple potential sources of racial, ethnic, and socioeconomic disparities in access to and utilization of follow-up services. Engage communities to understand the benefits of screening and to address concerns about stigmatization of families or communities in the screening process. Advocate with and on behalf of communities for the follow-up services that are needed.	Number of materials and resources disseminated. Number of preventive screenings conducted for physical and mental/emotional health. Report the degree of follow-up for children and youth identified with special health care needs. Report the degree of outreach to diverse cultures and communities regarding early screening and diagnosis.

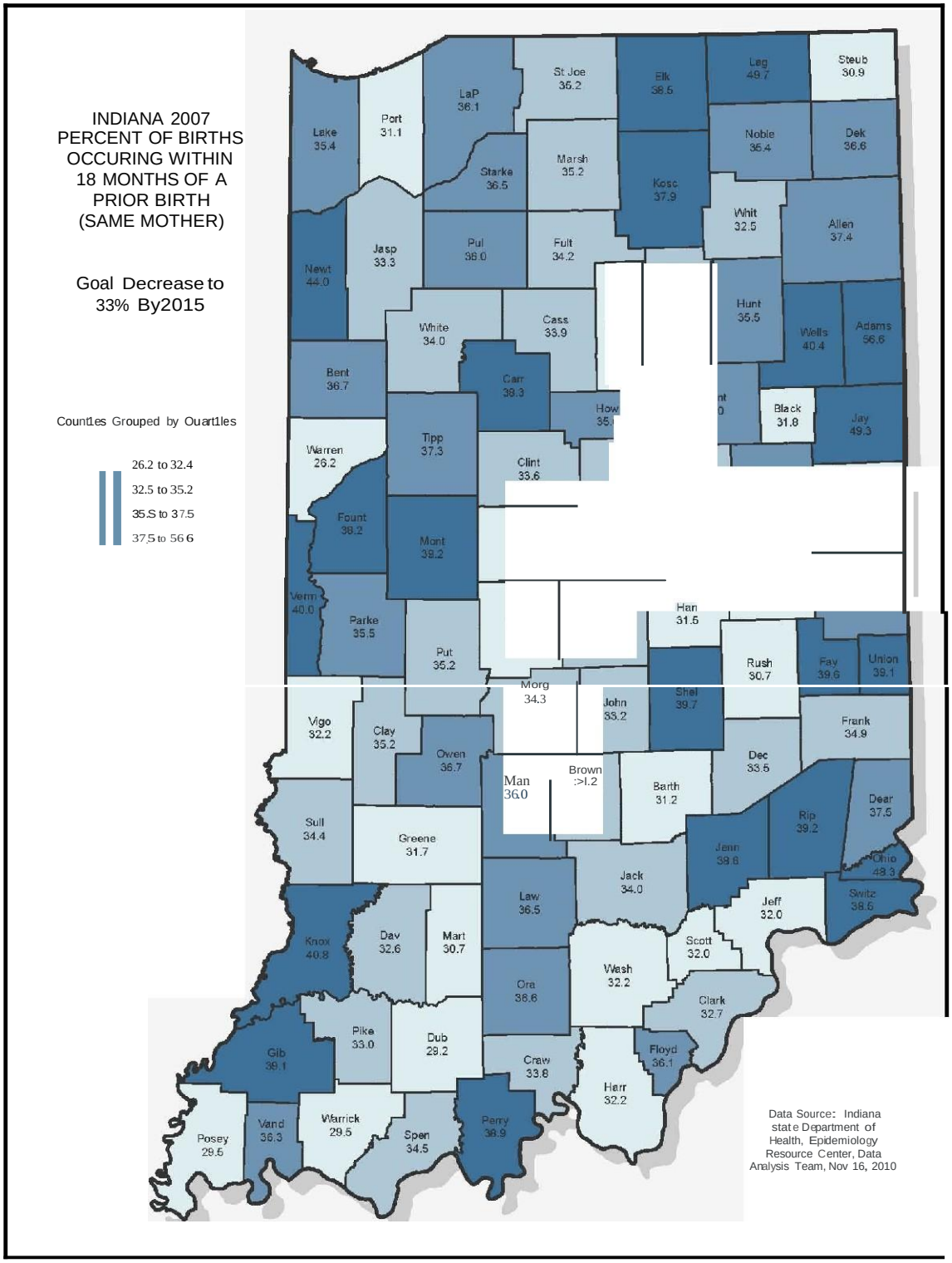
NPA#5 (services): Increase percent of children with special health care needs age 0-21 whose families report the community-based service system are organized so they can use them easily.	Develop/provide resources to community-based practices for care coordination Assist in compiling a directory of community services Community-level councils/coalitions/support groups. Promote Community-based versus centralized health care Promote cultural brokers /community health works/promoters to ensure needs of all families are met (cultural competence requires that organizations and their personnel have the capacity to: value diversity; conduct self assessment; manage the dynamic of difference; acquire and institutionalize cultural knowledge; and adapt to diversity and the cultural contexts of individuals and communities served)	Report the degree to which the project effectively addresses the needs of culturally and linguistically diverse groups Report cultural competence trainings for organization staff.
NPA#6 (transition services): Increase percent of youth with special health care needs who received the services necessary to make transition to all aspects of adult life, including adult health care, work, and independence.	Provide transition care services to youth and adults with special health care needs. Increase number of youth and adults with chronic conditions who have at least annual primary care, and when appropriate, specialty visits. Decrease barriers to community-based services through collaboration with other agencies including workgroups with physicians, other health care providers, education, and workforce development, business, health care funding, transportation, person support, and poverty. Utilize information from National Center for CYSHCN's transition to adult health care, work and independence and other resources	Number of CYSHCN provided with transition services. Number of CYSHCN who have a PCP. Number of collaborative opportunities. Number of transition resources developed and disseminated for CYSHCN. Number of transition and health fairs attended on behalf of CYSHCN Number of state Transition Workbooks disseminated or referrals to the Transition Workbook online.

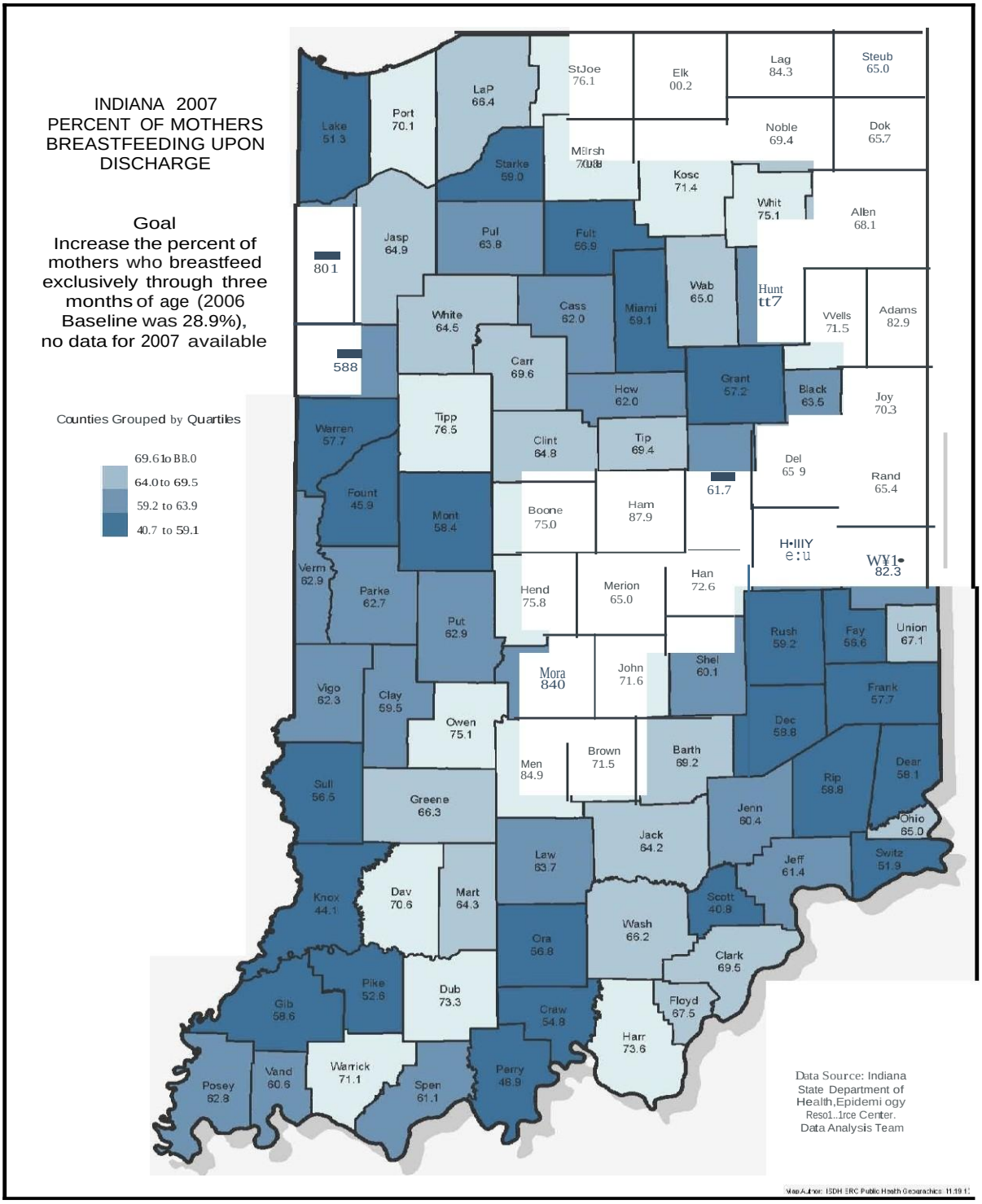
Indicator Maps
&
Additional Resources

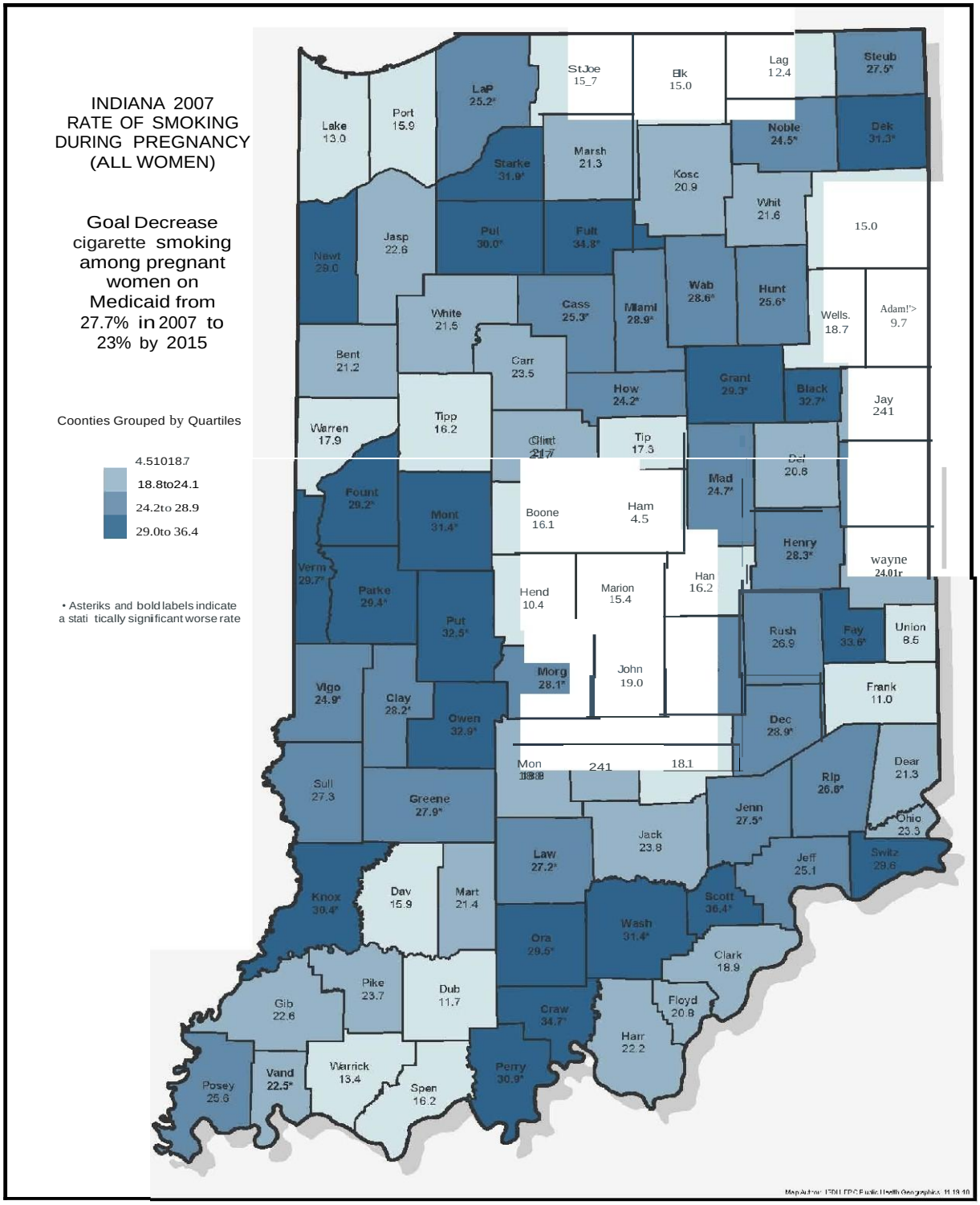
MAPS

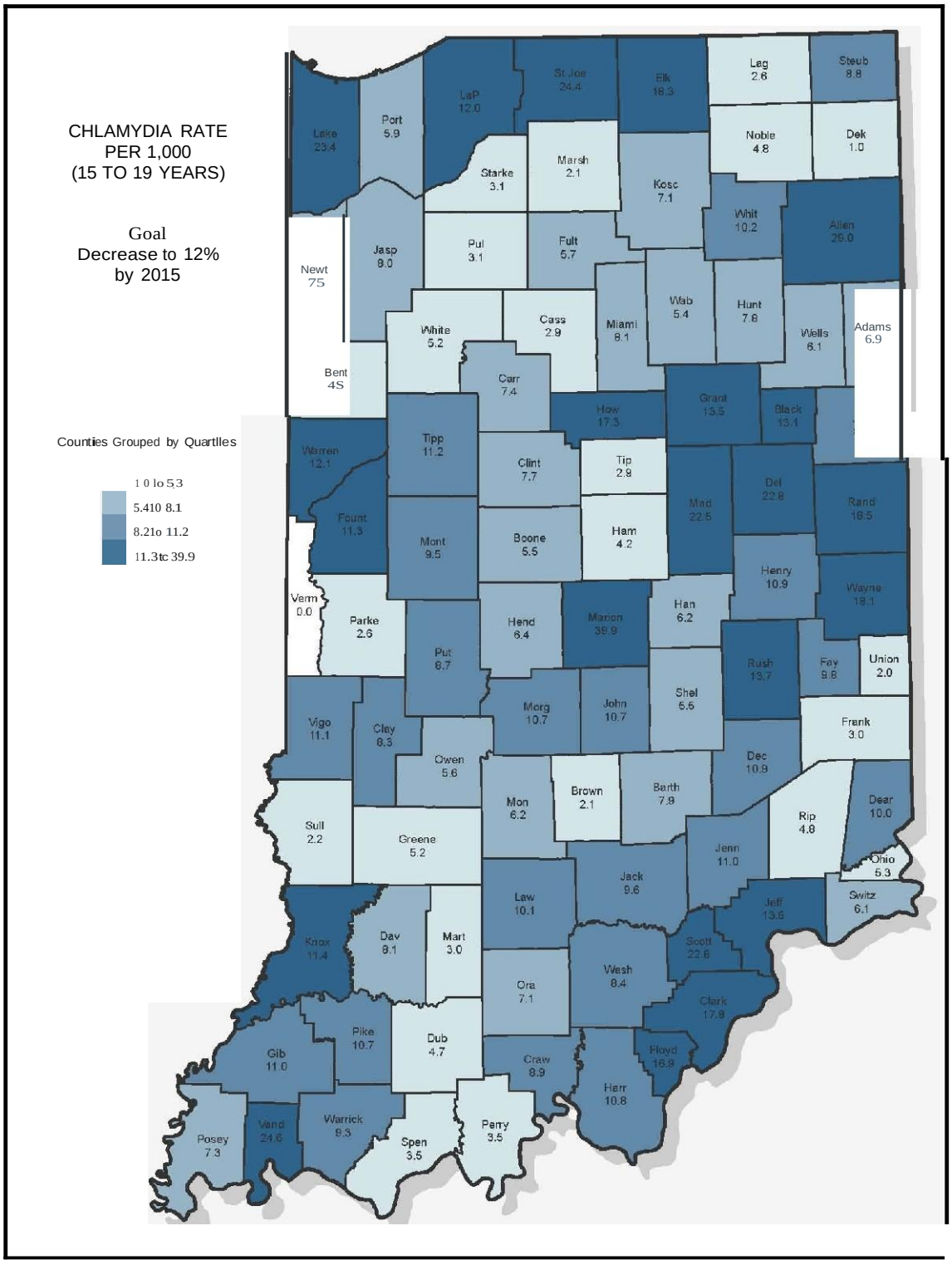

INDIANA 2007
PRETERM
BIRTH RATE
Goal
Decrease 10.8
By 2015
Counties Grouped by Quartiles
3.9 to 8.8
8.9 to 10.1
10.2 to 11.6
11.6 to 15.1
• Asteriks and bold labels indicate a statistically significant worse rate
Lake 13.7*
Port 10.1
LaP 13.4
Starke 7.9
Loop 10.7
8.6
White 11.2
Cass 8.6
Miami 7.9
Wab 15.1
Hunt 11.5
Wells 11.6
Amms 10.0
Bent 5.8
Carr 3.9
How 7.3
Grant 13.7
Black 8.3
Jay 12.5
Warren 9.0
Tip 8.1
Del 11.9
Rind 10.8
Fount 9.6
Mont 10.1
Boone 9
Ham 9.4
Mad 9.9
Henry 11.9
Wayne 9.0
Verm 12.0
Parke 5.4
Put 7.4
Hend 12.6
Marion 12.0*
Han 10.1
Rush 12.6
Fay 12.8
Union 6.1
Vigo 11.1
Clay 10.7
Owen 10.8
MOll 109
Jo n 89
Shel 10.8
Frank 8.7
Dec 9.7
Mon 8.1
Brown 6.6
Barth 8.7
Rip 8.9
Dear 10.8
Sull 11.1
Greene 10.5
Jenn 8.9
Ohio 13.3
Jack 10.6
Law 11.0
Jeff 10.4
Switz 10.4
Knox 9.5
Dav 10.2
Mart 12.9
Scott 10.7
Wash 7.3
Ora 11.7
Clark 12.8
Pike 13.2
Dub 9.3
Gib 11.5
Craw 8.9
Floyd 9.8
Harr 14
Posey 10.8
Vand 13.9*
Warrick 12.1
Spen 9.3
Perry 13.5
Data Source
Indiana State Department
of Health, Epidemiology
Resource Center, Data
Analysis Team, April 10, 2010

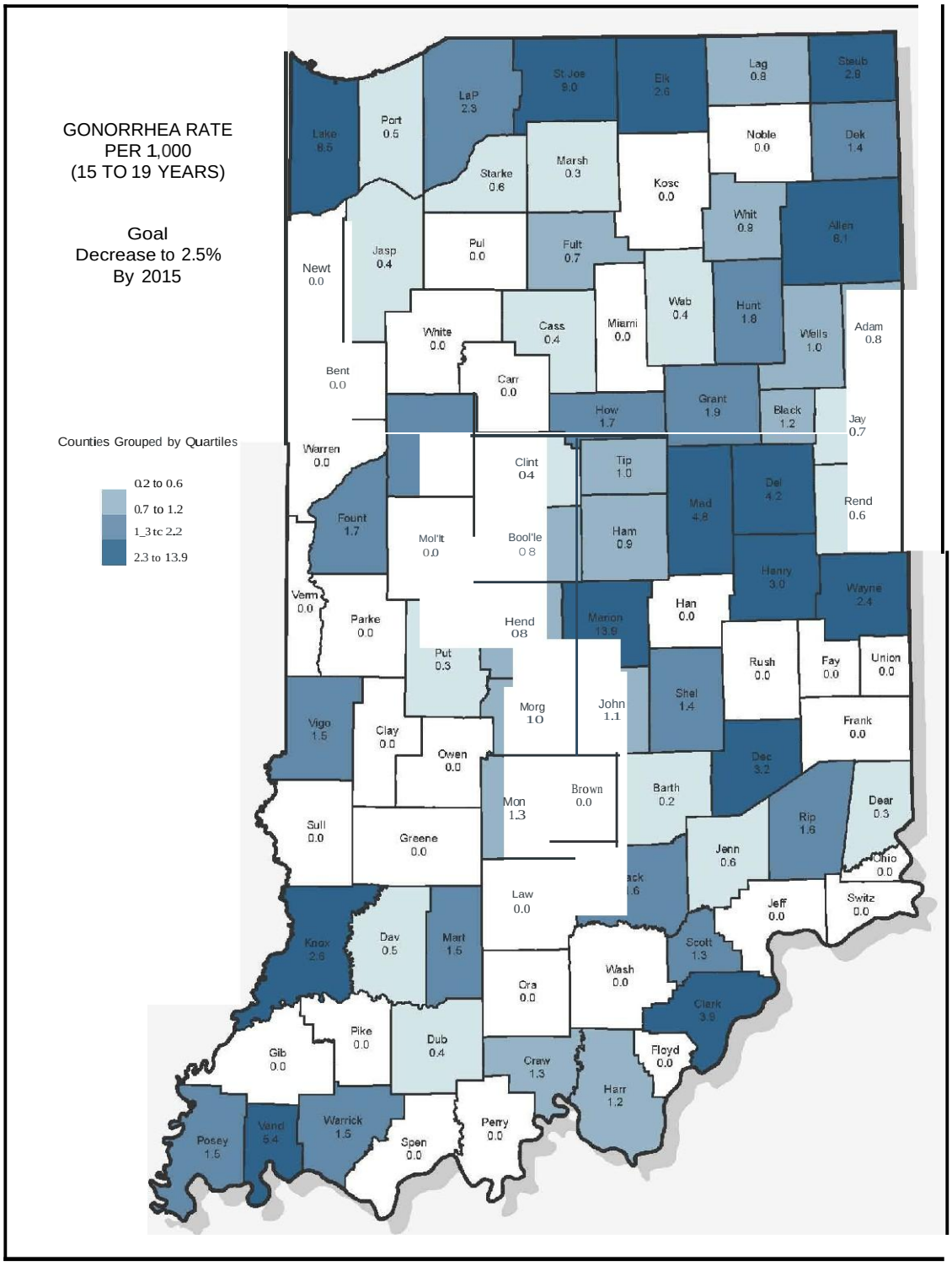

INDIANA 2007
KOTELCHUCK
(ADEQUATE OR BETTER)
BLACK WOMEN
AGES 15 TO 44 YEARS
Goal
Increase to 90%
(HP goal)
Counties Grouped by Ou artiles
89.5 to 100.0
67.9 to 89.4
50.1 to 67.8
Italisized labels indicate unstable rate (n ·20)
Lake 55.1
Port 65.5
LaP 58.0
St Joe 43.7
Elk 36.8
Lag 50.0
Steub 100.0
Dok 100.0
Noble 50.0
Kosc 66.7
Marsh 100.0
Starke 0.0
Whit 0.0
Ahn 87.9
Jasp 50.0
Pul 100.0
Fult 100.0
Newt 0.0
Wab 50.0
Hunt 0.0
Wds 750
Adsms 100.0
Cass 72.7
Miami 54.5
White 0.0
Bent 0.0
Carr 0.0
How 60.0
Grant 47.7
Black 0.0
Jay 0.0
Warren 100.0
Tipp 42.1
Clint 50.0
Tip 0.0
Del
Fount 50.0
Mont 50.0
Boone 100.0
Ham 80.3
69.7
0.0
Henry 77.8
Wayne 69.2
Verm 0.0
Parke 0.0
Had eu
Han 78.3
Put 100.0
Rush 100.0
Union 100.0
Vigo 70.3
Clay 100.0
Morg 0.0
John 89.5
She! 100.0
Frank 0.0
Owen 50.0
Dec 0.0
Sull 100.0
Greene 100.0
Mon 69.1
Brown 0.0
Barth 42.9
Rip 100.0
Dear 80.0
Jenn 0.0
Ohio 0.0
Law 100.0
Jack 83.3
Switz 0.0
Jeff 83.3
Knox 66.7
Dav 0.0
Mart 0.0
Scott 0.0
Wash 25.0
Ora 25.0
Clark 67.5
Pike 100.0
Dub 66.7
Gib 61.5
Craw 0.0
Floyd 59.4
Harr 50.0
Posey 66.7
Vand 52.8
Warrick 81.3
Spen 50.0
Perry 0.0


INDIANA 2007
PERCENT OF BIRTHS
OCCURING WITHIN
18 MONTHS OF A
PRIOR BIRTH
(SAME MOTHER)
Goal Decrease to
33% By2015
Count1es Grouped by Ouart1les
26.2 to 32.4
32.5 to 35.2
35.S to 37.5
37.5 to 56 6
Lake 35.4
Port 31.1
LaP 36.1
St Joe 35.2
Elk 38.5
Leg 49.7
Steub 30.9
Noble 36.4
Dek 36.6
Marsh 35.2
Starke 36.5
Kosc 37.9
Whit 32.5
Allen 37.4
Newt 44.0
Jasp 33.3
Pul 36.0
Fult 34.2
Hunt 35.5
Wells 40.4
Adams 56.6
White 34.0
Cass 33.9
Bent 36.7
Carr 38.3
How 35.
Black 31.8
Jay 49.3
Warren 26.2
Tipp 37.3
Clint 33.6
Fount 38.2
Mont 39.2
Verm 40.0
Parke 35.5
Put 35.2
Han 31.5
Rush 30.7
Fay 39.6
Union 39.1
Morg 34.3
John 33.2
Shel 39.7
Frank 34.9
Vigo 32.2
Clay 35.2
Owen 36.7
Dec 33.5
Man 36.0
Brown :>I.2
Barth 31.2
Dear 37.5
Sull 34.4
Greene 31.7
Rip 39.2
Jenn 39.8
Ohio 48.3
Jack 34.0
Switz 38.6
Law 36.5
Jeff 32.0
Knox 40.8
Dav 32.6
Mart 30.7
Scott 32.0
Wash 32.2
Ora 36.6
Clark 32.7
Pike 33.0
Dub 29.2
Gib 39.1
Floyd 36.1
Craw 33.8
Harr 32.2
Posey 29.5
Vand 36.3
Warrick 29.5
Spen 34.5
Perry 38.9
Data Source: Indiana
state Department of
Health, Epidemiology
Resource Center, Data
Analysis Team, Nov 16, 2010

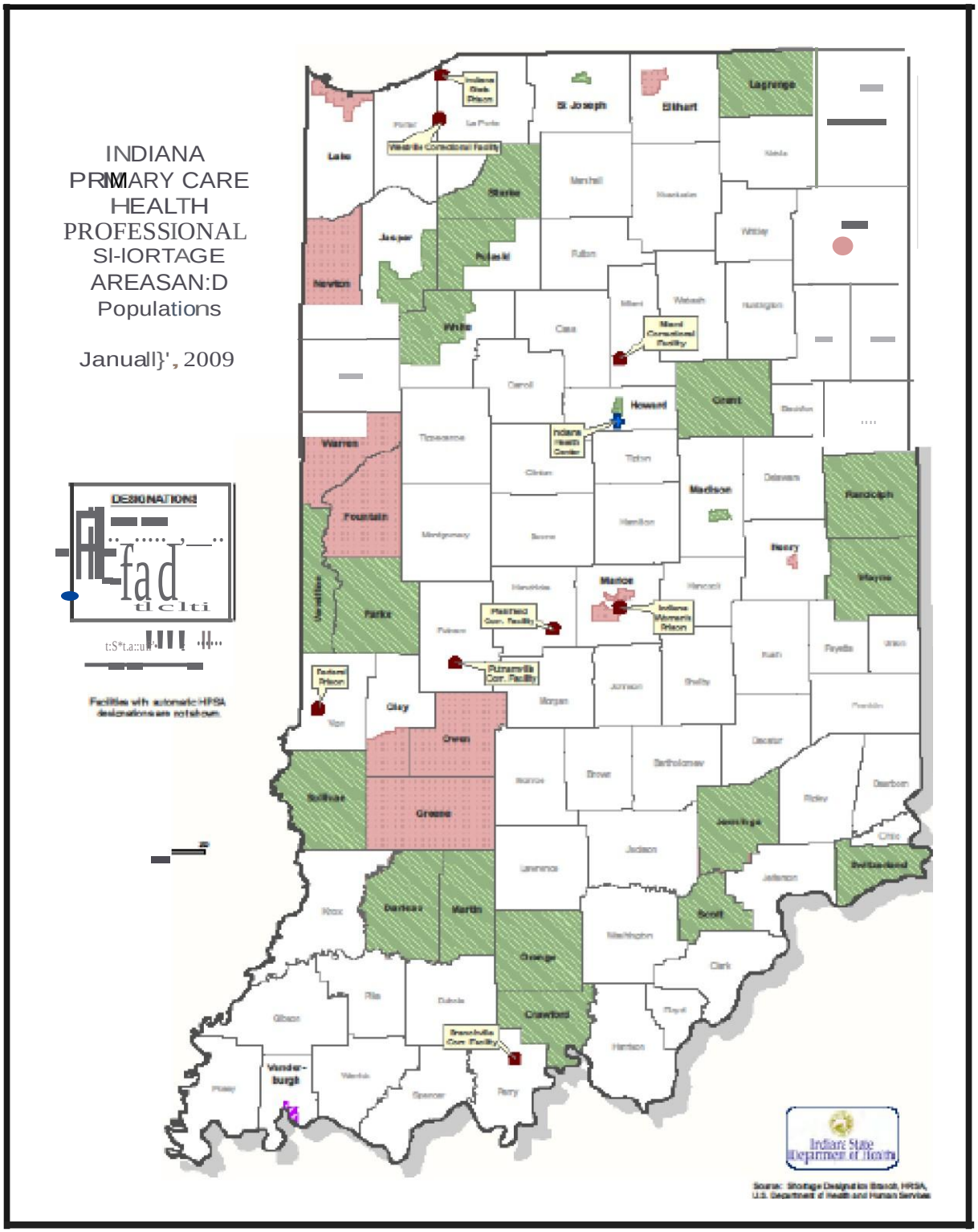

INDIANA 2007
PERCENT OF MOTHERS
BREASTFEEDING UPON
DISCHARGE
Goal
Increase the percent of mothers who breastfeed exclusively through three months of age (2006 Baseline was 28.9%), no data for 2007 available
Counties Grouped by Quartiles
69.61 to 88.0
64.0 to 69.5
59.2 to 63.9
40.7 to 59.1
Lake 51.3
Port 70.1
LaP 66.4
StJoe 76.1
Elk 00.2
Lag 84.3
Steub 65.0
Noble 69.4
Dok 65.7
Starke 59.0
Kosc 71.4
Whit 75.1
Allen 68.1
Jasp 64.9
Pul 63.8
Fult 66.9
Wab 65.0
Hunt tt7
Wells 71.5
Adams 82.9
White 64.5
Cass 62.0
Miami 59.1
Carr 69.6
How 62.0
Grant 57.2
Black 63.5
Joy 70.3
Warren 57.7
Tipp 76.5
Clint 64.8
Tip 69.4
Del 65 9
Rand 65.4
Fount 45.9
Mont 58.4
Boone 75.0
Ham 87.9
61.7
Verm 62.9
Parke 62.7
Put 62.9
Hend 75.8
Merion 65.0
Han 72.6
W¥1• 82.3
Rush 59.2
Fay 56.6
Union 67.1
Vigo 62.3
Clay 59.5
Owen 75.1
Mora 840
John 71.6
Shel 60.1
Frank 57.7
Dec 58.8
Sull 56.5
Greene 66.3
Men 84.9
Brown 71.5
Barth 69.2
Rip 58.8
Dear 58.1
Jenn 60.4
Ohio 65.0
Jack 64.2
Law 63.7
Switz 51.9
Jeff 61.4
Knox 44.1
Dav 70.6
Mart 64.3
Scott 40.8
Wash 66.2
Ora 56.8
Clark 69.5
Pike 52.6
Dub 73.3
Gib 58.6
Craw 54.8
Floyd 67.5
Harr 73.6
Posey 62.8
Vand 60.6
Warrick 71.1
Spen 61.1
Perry 48.9
Data Source: Indiana State Department of Health, Epidemiology Resource Center. Data Analysis Team

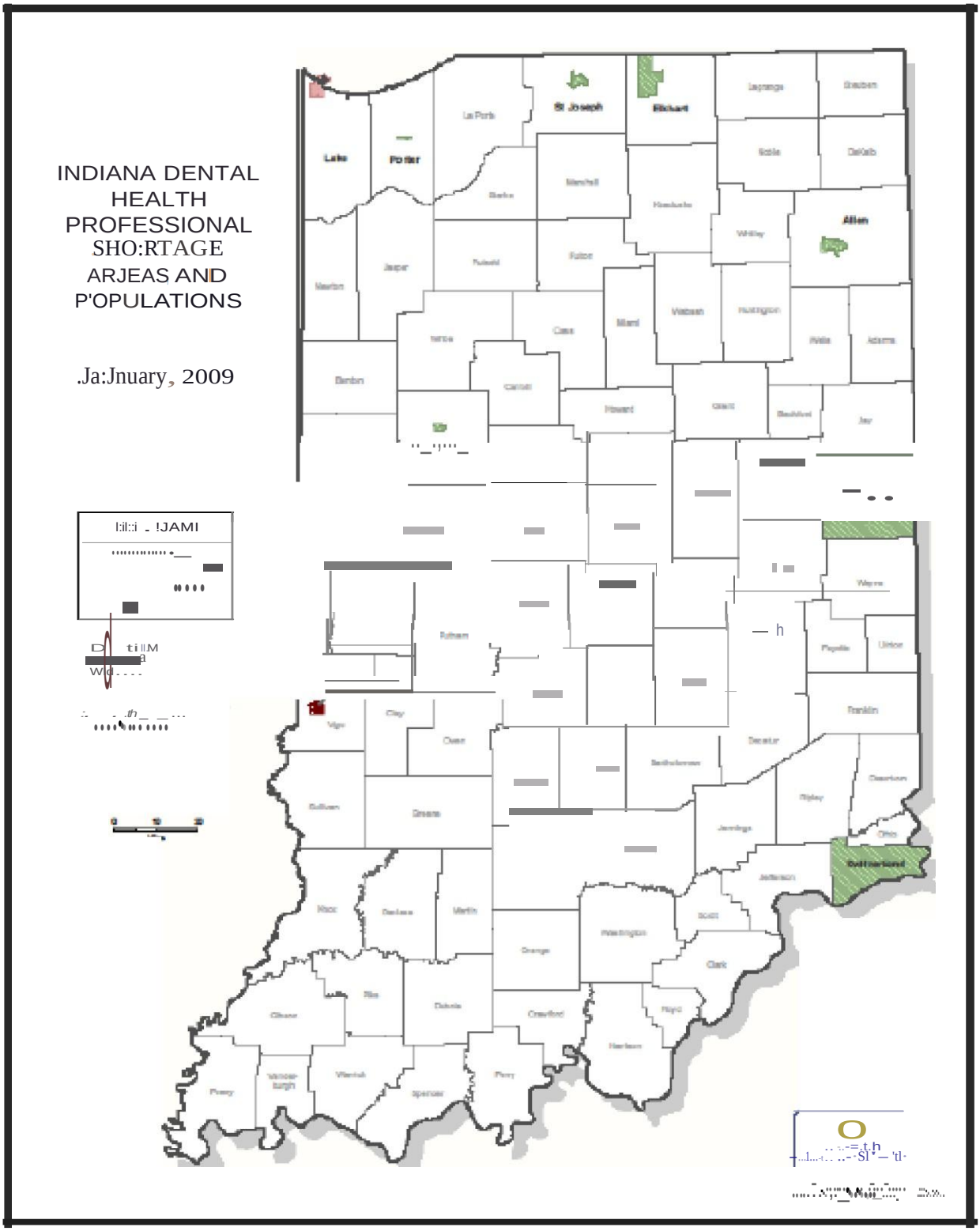

INDIANA 2007
RATE OF SMOKING
DURING PREGNANCY
(ALL WOMEN)
Goal Decrease cigarette smoking among pregnant women on Medicaid from 27.7% in 2007 to 23% by 2015
Coonties Grouped by Quartiles
4.510187
18.8to24.1
24.2to 28.9
29.0to 36.4
• Asteriks and bold labels indicate a stati tically signi ficant worse rate
Lake 13.0
Port 15.9
LaP 25.2*
StJoe 15_7
Elk 15.0
Lag 12.4
Steub 27.5*
Dek 31.3*
Noble 24.5*
Starke 31.9*
Marsh 21.3
Kosc 20.9
Whit 21.6
15.0
Newt 29.0
Jasp 22.6
Pul 30.0*
Fult 34.8*
Wab 28.6*
Hunt 25.6*
Wells. 18.7
Adam!'> 9.7
White 21.5
Cass 25.3*
Miami 28.9*
Bent 21.2
Carr 23.5
How 24.2*
Grant 29.3*
Black 32.7*
Jay 241
Warren 17.9
Tipp 16.2
Clint 21.7
Tip 17.3
Del 20.6
Mad 24.7*
Fount 29.2*
Mont 31.4*
Boone 16.1
Ham 4.5
Henry 28.3*
wayne 24.01r
Verm 29.7*
Parke 29.4*
Hend 10.4
Marion 15.4
Han 16.2
Put 32.5*
Rush 26.9
Fay 33.6*
Union 8.5
Morg 28.1*
John 19.0
Vigo 24.9*
Clay 28.2*
Owen 32.9*
Frank 11.0
Dec 28.9*
Mon 18.8
241
18.1
Dear 21.3
Sull 27.3
Greene 27.9*
Rip 26.6*
Jenn 27.5*
Ohio 23.3
Jack 23.8
Law 27.2*
Switz 29.6
Jeff 25.1
Knox 30.4*
Dav 15.9
Mart 21.4
Scott 36.4*
Wash 31.4*
Ora 29.5*
Clark 18.9
Pike 23.7
Dub 11.7
Gib 22.6
Craw 34.7*
Floyd 20.8
Harr 22.2
Posey 25.6
Vand 22.5*
Warrick 13.4
Spen 16.2
Perry 30.9*


CHLAMYDIA RATE
PER 1,000
(15 TO 19 YEARS)
Goal
Decrease to 12%
by 2015
Counties Grouped by Quartlles
1 0 lo 5.3
5.410 8.1
8.21o 11.2
11.3tc 39.9
Lake 23.4
Port 5.9
LaP 12.0
St Joe 24.4
Elk 18.3
Leg 2.6
Steub 8.8
Noble 4.8
Dek 1.0
Marsh 2.1
Starke 3.1
Kosc 7.1
Whit 10.2
Allen 29.0
Jasp 8.0
Pul 3.1
Fult 5.7
Newt 75
Wab 5.4
Hunt 7.8
Wells 6.1
Adams 6.9
White 5.2
Cass 2.9
Miami 8.1
Bent 4S
Carr 7.4
How 17.3
Grant 13.5
Black 13.1
Warren 12.1
Tipp 11.2
Clint 7.7
Tip 2.9
Mad 22.5
Del 22.8
Rand 18.5
Fount 11.3
Mont 9.5
Boone 5.5
Ham 4.2
Henry 10.9
Wayne 18.1
Verm 0.0
Parke 2.6
Hend 6.4
Marion 39.9
Han 6.2
Put 6.7
Rush 13.7
Fay 9.8
Union 2.0
Vigo 11.1
Clay 8.3
Morg 10.7
John 10.7
Shel 6.5
Frank 3.0
Owen 5.6
Dec 10.9
Mon 6.2
Brown 2.1
Barth 7.9
Dear 10.0
Sull 2.2
Greene 5.2
Rip 4.8
Jenn 11.0
Ohio 5.3
Jack 9.6
Law 10.1
Jeff 13.6
Switz 6.1
Knox 11.4
Dav 9.1
Mart 3.0
Scott 22.6
Wash 8.4
Ora 7.1
Clark 17.9
Pike 10.7
Dub 4.7
Gib 11.0
Craw 8.9
Floyd 16.8
Harr 10.8
Posey 7.3
Vand 24.6
Warrick 9.3
Spen 3.5
Perry 3.5


GONORRHEA RATE
PER 1,000
(15 TO 19 YEARS)
Goal
Decrease to 2.5%
By 2015
Counties Grouped by Quartiles
0.2 to 0.6
0.7 to 1.2
1.3 to 2.2
2.3 to 13.9
Lake 8.5
Port 0.5
LaP 2.3
St Joe 9.0
Elk 2.6
Lag 0.8
Steub 2.9
Noble 0.0
Dek 1.4
Starke 0.6
Marsh 0.3
Kosc 0.0
Whit 0.8
Allen 8.1
Jasp 0.4
Pul 0.0
Fult 0.7
Newt 0.0
Wab 0.4
Hunt 1.8
Wells 1.0
Adam 0.8
White 0.0
Cass 0.4
Miami 0.0
Bent 0.0
Carr 0.0
How 1.7
Grant 1.9
Black 1.2
Jay 0.7
Warren 0.0
Clint 04
Tip 1.0
Del 4.2
Mad 4.8
Rend 0.6
Fount 1.7
Mol'lt 0.0
Bool'le 0 8
Ham 0.9
Henry 3.0
Wayne 2.4
Verm 0.0
Parke 0.0
Hend 08
Marion 13.9
Han 0.0
Put 0.3
Rush 0.0
Fay 0.0
Union 0.0
Vigo 1.5
Clay 0.0
Morg 10
John 1.1
Shel 1.4
Frank 0.0
Owen 0.0
Dec 3.2
Mon 1.3
Brown 0.0
Barth 0.2
Dear 0.3
Sull 0.0
Greene 0.0
Rip 1.6
Jenn 0.6
Ohio 0.0
Law 0.0
Jeff 0.0
Switz 0.0
Knox 2.6
Dav 0.5
Mart 1.5
Scott 1.3
Wash 0.0
Ora 0.0
Clark 3.9
Pike 0.0
Gib 0.0
Dub 0.4
Craw 1.3
Floyd 0.0
Harr 1.2
Posey 1.5
Vand 5.4
Warrick 1.5
Spen 0.0
Perry 0.0

MAPS (CONTINUED)




INDIANA DENTAL HEALTH PROFESSIONAL SHO:RTAGE ARJEAS AND P'OPULATIONS
.Ja:Jnuary, 2009
St Joseph
Elkhart
Lake
Porter
LaPorte
Allen
Wayne
Franklin
Switzerland
Clark
Floyd
Harrison
Crawford
Perry
Spencer
Vanderburgh
Warrick
Vigo
Clay
Owen
Greene
Knox
Daviess
Martin
Orange
Washington
Jefferson
Jennings
Ripley
Dearborn
Ohio
Decatur
Fulton
Union

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MCH DEFINITIONS & RESOURCES

Service Category: A MCSHCS population of focus, including (a) Pregnant Women / Infants; (b) Children ages 1-9; (c) Adolescents ages 10 – 24; (d) Women of Childbearing Age 14-44; and (e) Children with Special Health care Needs ages 0-21.

Client: A recipient of services that are supported by program expenses funded in whole or in part by the TITLE V or local TITLE V matching dollars

Program Expenses: Any expense included in the budget that the TITLE V project proposes to be funded by TITLE V or TITLE V matching dollars (includes staff, supplies, space costs, etc.)

Matching Funds: At least 30% of the TITLE V award

All dollars the project assigns to support the TITLE V funded service (includes Medicaid or other income generated by service provision)

Types of Clients: Pregnant women, infants, children, adolescents, adult women, children and youth with special health care needs and families.

MCH Supported Services:

Direct medical and dental care: Family Planning, Prenatal Care, Child Health (infant, child adolescent), Women's Health,

Enabling services: Prenatal Care Coordination, Family Care Coordination, CYSHCN Care Coordination and Transition services.

Health Insurance Portability and Accountability Act (HIPAA):

Prenatal Care Coordination (PNCC):

The primary objective of the perinatal health care program is to decrease infant mortality and low birthweight infants by providing holistic health care to low income pregnant women in community settings. Please follow link for more information (http://www.in.gov/isdh/21041.htm).

Cultural Competency: Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum. (Adapted from Cross et al., 1989). Cultural competence requires that organizations:

> Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally.
>
> Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve.
>
> Incorporate the above in all aspects of policy making, administration, practice, service delivery and involve systematically consumers, key stakeholders and communities.

WEBSITE RESOURCES

FY 2011MCH Grant Funding Announcement Document:
http://www.in.gov/isdh/programs/mch/grantopportunities/grantopportunities.htm

FY 2011MCH Grant Application Document
http://www.in.gov/isdh/programs/mch/grantopportunities/grantopportunities.htm

YRBS: www.in.gov/yrbs or http://www.in.gov/isdh/20627.htm

National Center for Cultural Competence:
http://www11.georgetown.edu/research/gucchd/nccc/

ASK (About Special Kids): http://www.aboutspecialkids.org/

Children with Special Health Care Needs: http://www.in.gov/isdh/19613.htm

Sunny Start: http://www.in.gov/isdh/21190.htm

Indiana's Five Year Needs Assessment FY 2011 -2015:

http://www.in.gov/isdh/files/Indiana_FY_2011-2015_Needs_Assessment.pdf
Indiana Tobacco Quitline: http://www.in.gov/quitline/ and hotline: 1-800-QUIT-NOW (800-784-8669)
SMART Objectives: http://www.cdc.gov/phin/communities/resourcekit/tools/evaluate/smart_objectives.html
Maternal and Child Health Bureau: http://mchb.hrsa.gov/
ISDH Prenatal Care Coordination: http://www.in.gov/isdh/21041.htm
Indiana Healthy Weight Initiative: www.inhealthyweight.org
INSHAPE Indiana: http://www.in.gov/inshape/
ISDH Immunizations: http://www.in.gov/isdh/17094.htm
Life-course Perspective: http://mchb.hrsa.gov/lifecourseresources.htm.
National Chapter Family Voices: http://www.familyvoices.org/
Family Voices Indiana: http://fvindiana.blogspot.com/

Grant Application Scoring Tool

GRANT APPLICATION SCORING TOOL

Applicant Agency: _____
Project Title: _____
Reviewer: _____
Date of Review _____

SECTION 2: COMPLETION CHECKLIST

Is the Completion Checklist complete?		1 points max
Did the grantee select the checkbox indicating that applicant agency has notified its Local Health Officer about its intent to apply for TITLE V funding?		1 points max

SCORE: _____ / __2__ POINTS MAX

SECTION 3: APPLICATION COVER PAGE

Is the Application Cover Page complete?		4 points max
Did the grantee list Name, Title, and Signature of Authorized Executive Official?		1 points max
Did the grantee list Name, Title, and Signature of Project Director?		1 points max
Did the grantee list Name, Title, and Signature of the Person of Contact?		1 points max
Did the grantee list Name, Title, and Signature of person authorized to make legal and contractual agreements?		1 points max

SCORE: _____ / __4__ POINTS MAX

SECTION 4: ABSTRACT

Did the grantee briefly describe the purpose of the proposed project and the anticipated accomplishments (goals), including knowledge gained, and describe the measurable objectives to achieve the accomplishments?		4 points max
Did the grantee briefly describe the target population and its needs and discuss why the specific interventions proposed are expected to have a substantial positive impact on the appropriate performance measure(s)		4 points max

SCORE: _____ / _8___ POINTS MAX

SECTION 5: APPLICATION NARRATIVE

SECTION 5-A: ORG BACKGROUND / CAPACITY

Discuss the history, capability, experiences, and major accomplishments of the applicant organizations		2 points max
Discuss the history, capability, experiences, and major accomplishments of the partnering organizations		2 points max

SCORE: _____ / __4__ POINTS MAX

SECTION 5-B: NEEDS ASSESSMENT

Describe and justify your population(s) of focus (demographic information on the population of focus, such as race, ethnicity, age, socioeconomic status, geography must be provided).		2 points max
Describe and justify the *geographic area* to be served.		2 points max
Describe the needs and extent of the need (e.g. current prevalence rates or incidence data) for the population(s) of focus based on data.		2 points max
Provide sufficient information on how the data were collected so reviewers can assess the reliability and validity of the data.		1 points max
The quantitative data can come from local epidemiologic data, State data (e.g. from state needs assessment or state vital statistics data), and/or national data.		2 points max
Please site all references (do not include copies of sources).		1 points max
Describe how the needs were identified.		2 points max
Describe existing service gaps.		2 points max

SCORE: _____ / _14___ POINTS MAX

SECTION 5-C: GOALS & OBJECTIVES

Provide the overall project goal and each objective. Ensure the objectives are *S*pecific, *M*easurable, *A*chievable, *R*ealistic, and *T*ime-bound (SMART Objectives)		3 points max
Clearly state the unduplicated number of individuals you propose to serve (annually and over the entire project period) with grant funds, including the types and numbers of services to be provided and the anticipated outcomes.		3 points max
Describe how achievement of the goals will produce meaningful and relevant results (e.g. increase access, availability, prevention, outreach, treatment and/or intervention).		3 points max

Describe and provide a rationale for the anticipated <u>impact</u> the proposed project will have on your community (e.g., improve birth outcomes, decrease E.R. visits for CSHCN, decrease adolescent suicides). Impact is more goal-oriented, while results are more process oriented.		3 points max

SCORE: _____ / __12__ POINTS MAX

SECTION 5-D: ACTIVITIES

Describe how the proposed service(s) or practice(s) will be implemented.		2 points max
Describe how you will identify, recruit and retain the population(s) of focus. Using your knowledge of the language, beliefs, norms and values, and socioeconomic factors of the population(s) of focus, discuss how the proposed approach addresses these issues in outreaching, engaging, and delivering programs to this population e.g. collaborating with community gatekeepers.		3 points max
Describe how you will ensure the input of youth and families in assessing, planning and implementing your project.		2 points max
Identify any other organizations that will participate in the proposed project. Describe their roles and responsibilities and demonstrate their commitment to the project.		1 points max
Show that the necessary groundwork (e.g. planning, consensus development, development of memoranda of agreement, identification of potential facilities) has been completed or is near completion so that the project can be implemented and service delivery begin as soon as possible and no later than 4 months after the grant award.		2 points max
Describe the potential barriers to successful conduct of the proposed project and how you will overcome them.		2 points max
Describe your plan to continue the project after the funding period ends (sustainability). Also, describe how program continuity will be maintained when there is a change in the operational environment (e.g. staff turnover, change in project leadership) to ensure stability over time.		2 points max

SCORE: _____ / _14___ POINTS MAX

SECTION 5-E: STAFFING PLAN

List and describe the staff positions for the project (within the applicant agency and its partner organizations)		1 points max
Regardless of whether a position is filled or to be announced, please discuss how key staff have / will have: experience working with the proposed population; appropriate qualifications to serve the population(s) of focus; familiarity with cultures and languages or the proposed populations.		1 points max
For positions already filled, provide a brief BioSketch, found in the TITLE V APPLICATION document Section 7-A for five key		1 points max

personnel (note: more than five may be listed, but please include only five BioSketches.		
For position to be announced and positions currently filled, please provide a brief Job Description, found in the TITLE V APPLICATION document Section 7-B for up to five key personnel to be hired (note: more than five may be hired, but please include only five Job Descriptions).		1points max
For positions already filled, please provide the license number for all RNs and physicians.		1 points max

SCORE: _____ / __5__ POINTS MAX

SECTION 5-F: RESOURCE PLAN

Describe resources available (within the applicant agency and its partner organizations) for the proposed project (e.g., facilities, equipment)		1 points max
Provide evidence that services will be provided in a location that is adequate and accessible.		1 points max
Assure that project facilities will be smoke-free at all times		1 points max
Assure that hours of operation are posted and visible from outside the facilities.		1 points max
Explain how the facilities/equipment are compliant with the Americans with Disabilities Act (ADA) and amenable to the population(s) of focus. If the ADA does not apply to your organization, explain why.		1 points max

SCORE: _____ / __5__ POINTS MAX

SECTION 5-G: EVIDENCE-BASED PROGRAMMING

Discuss the evidence that shows that this practice is effective with your population(s) of focus.		2 points max
If the evidence is limited or non-existent for your population(s) of focus, provide other information to support your selection of the intervention(s) for the population(s).		2 points max
Identify and justify any modifications or adaptations you will need to make (or have already made) to the proposed practice(s) to meet the goals of your project and why you believe the changes will improve the outcomes.		2 points max

SCORE: _____ / _6___ POINTS MAX

SECTION 5-H: EVALUATION PLAN

Process Outcomes Evaluation		
Describe plan for data *collection*. Specify and justify all measures or instruments you plan to use.		1 points max
Describe plan for data *management*. List responsible staff.		1 points max
Describe plan for data *analysis.* List responsible staff.		1 points max
Describe plan for data *reporting*.		1 point max
Objective Outcome Evaluation		
List specific measurable outcomes for each *objective* and its corresponding *activities* listed in Sections 7-D (Action Plan Tables) and 7-E (Outcome Forms)		1 point max
Overall Outcome Evaluation		
Describe plan of action if process outcomes or objective outcomes are not on target during a quarterly or year-end evaluation		1 point max
Describe who is responsible for revisiting activities to make changes for improved outcomes.		1 point max
Describe how new data as a result of the program will be used to guide the project in the future.		1 point max
Describe how process outcomes and objective outcomes will be disseminated to stakeholders within the applicant agency, its partnering agencies, and throughout local and statewide communities.		1 point max

SCORE: _____ / _9___ POINTS MAX

SECTION 5-I: LITERATURE CITATIONS

Are all literature citations included.		2.5 points max

SCORE: _____ / _2.5___ POINTS MAX

SECTION 6: BUDGET INFORMATION

SECTIONS 6-A TO 6-H: BUDGET INFORMATION

Section 6A Budget Revenue Form FY2014 is complete, numbers are accurate, and calculations are correct.		1 point max
Section 6B Budget Revenue Form FY2015 is complete, numbers are accurate, and calculations are correct.		1 point max
Section 6C Budget Match Form FY2014 is complete, numbers are accurate, and calculations are correct.		1 point max
Section 6D Budget Match Form FY2015 is complete, numbers are accurate, and calculations are correct.		1 point max
Section 6E Budget Expense Form FY2014 is complete, numbers are accurate, and calculations are correct.		1 point max
Section 6F Budget Expense Form FY2015 is complete, numbers are accurate, and calculations are correct.		1 point max
Section 6G Budget Narrative Form FY2014 is complete, numbers are accurate, and calculations are correct.		2 points max
Section 6H Budget Narrative Form FY2015 is complete, numbers are accurate, and calculations are correct.		2 points max

SCORE: _____ / 10_ POINTS MAX

SECTION 7: REQUIRED ATTACHMENTS

Section 7-A Biosketches (Are all required biosketches included)		.5 points max
Section 7-B Job Descriptions (Are all job descriptions included)		.5 points max
Section 7-C Timeline (Is timeline complete and clear)		.5 points max
Section 7-D Action Plan Tables (Are Action Plan Tables complete)		.5 points max
Section 7-E Outcome Forms (Are outcome forms complete)		.5 points max

SCORE: _____ / __2.5__ POINTS MAX

SECTION 8: ADDITIONAL REQUIRED DOCUMENTS

SECTION 8: ADDIONAL REQUIRED DOCUMENTS

Quarterly & Annual Reports (Is grantee in compliance with submission of quarterly & annual reports).		3 points max

SCORE: _____ / __3__ POINTS MAX